UNIVERSITY OF PRIMORSKA
FACULTY OF HEALTH SCIENCE

COMMUNITY NURSING IN SLOVENIA AND SCOTLAND IN RELATION WITH FAMILY NURSE

PATRONAŽNO ZDRAVSTVENO VARSTVO V SLOVENIJI IN NA ŠKOTSKEM V POVEZAVI Z DRUŽINSKO MEDICINSKO SESTRO

Student: ANDREJA LJUBIČ, RN
Mentor: Prof. Dr. JUNE CLARK
Comentor: Msc. TAMARA ŠTEMBERGER KOLNIK, senior lecturer, RN
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ABSTRACT

In Slovenia the family/community nursing service is designed according to The World Health Organization policies and is performed by the generalist family/community nurse. Since very little has been written about the experiences and development of the community nursing service in Slovenia, we decided to perform a literature review in order to present the development of the community nursing in Slovenia, and compared it with the pilot study, which was implemented in Scotland according to the proposal and policies of The World Health Organization. This thesis uses the descriptive and comparative research methods relating to community health nursing in Slovenia and Scotland, and in particular to the development of the Family Health Nurse as advocated by The World Health Organization. Literature in both Slovenian and English was searched using national and international specialized databases. The main difference observed between the two systems of organization of community nursing is the generalist nursing role vs. specialist nursing role. The existing differences are the result of historical, cultural and political influences. The Slovenian generalist role is family and community centered, whereas in Scotland, community nurses' activities are focused on individual nursing care, and in recent decades the country has experienced a dramatic rise in the number of specialist community nurses. Even though there are clear benefits in both roles, it is necessary to keep the balance between the requirements of the profession and patients' needs.

Keywords: family health nurse, community health nursing, community nursing care, community nurse role

POVZETEK

Organizacija patronažne zdravstvene dejavnosti je v Sloveniji zasnovana v skladu z usmeritvami Svetovne zdravstvene organizacije in v taki obliki se je razvijala več kot štirideset let. Patronažno zdravstveno varstvo se izvaja kot polivalentna dejavnost osnovnega zdravstvenega varstva v okviru zdravstvenih domov ali pa kot samostojna služba zasebnega izvajalca zdravstvene dejavnosti. Patronažno zdravstveno nego opravlja medicinska sestra z višjo ali visoko strokovno izobrazbo na naslednjih področjih: zdravstveno-socialno obravnave posameznika, družine in skupnosti, zdravstvena nega otročnice in novorojenčka na domu in zdravstvena nega bolnika na domu. Izvajanje preventivne dejavnosti in promocije zdravja sta najpomembnejši nalogi patronažne zdravstvene nege, s pomočjo katere skušamo vplivati na ljudi, da postanejo dejavni, kar je temeljni pogoj, da lahko prevzamejo svoj del odgovornosti za lastno zdravje in da so motivirani do stopnje, ko si prizadevajo ohraniti lastno zdravje in zdravo življenjsko okolje ter dejavno sledijo sodobnim preventivnim ukrepom. Škotska nima univerzalnega modela patronažnega zdravstvenega varstva, kot je v Sloveniji, v zadnjih desetletjih je bil razvoj patronažne zdravstvene nege usmerjen v specialistične prakse, kar s seboj prinaša obilico različnih nazivov in s tem pogojenih delovnih mest. V patronažnem varstvu deluje osem različnih profilov medicinskih sester, zato ni presenetljivo, da je škotska vlada začela razmišljati o bolj univerzalnem modelu patronažne medicinske sestre. Tamkajšnje Ministrstvo za zdravje je vlogo »družinske medicinske sestre« po konceptu Svetovne zdravstvene organizacije videlo kot možno rešitev za nekatere težave, ki se pojavljajo pri zagotavljanju zdravstvenih storitev v oddaljenih in podeželskih območjih. Svetovna zdravstvena organizacija predstavlja »družinsko medicinsko sestro« kot ključnega strokovnjaka na primarnem nivoju, ki poleg izvajanja zdravstvene nege lahko veliko prispeva tudi na področju promocije zdravja in preprečevanja bolezni, lahko jo promovira kot strokovnjakinjo, ki deluje na več strokovnih področjih na določenem geografskem območju ter spremlja družino skozi različna življenjska obdobja na njihovem domu.

Namen magistrske naloge je predstaviti prednosti ter slabosti organizacije patronažnega zdravstvenega varstva v Sloveniji in na Škotskem, njene funkcije, lastnosti, naloge in področja delovanja. Ker je v Sloveniji zelo malo napisanega o izkušnjah in razvoju patronažne zdravstvene dejavnosti smo se odločili izvesti pregled literature, s katerim bi

predstavili razvoj patronažne zdravstvene nege v Sloveniji in to primerjali s pilotno študijo, ki je bila izvedena na Škotskem v skladu s predlogi Svetovne zdravstvene organizacije. Koncept »družinske medicinske sestre« v praksi ni popolnoma zaživel, kljub dejstvu, da je bila pilotska študija na Škotskem uspešno izvedena. Pregled literature temelji na deskriptivni in primerjalni raziskovalni metodi, ki se nanaša na patronažno zdravstveno varstvo v Sloveniji in na Škotskem, in zlasti na razvoj družinske medicinske sestre, kot jo zagovarja Svetovna zdravstvena organizacija. Iskanje del v slovenskem in angleškem jeziku je potekalo s pomočjo nacionalnih in svetovnih baz podatkov. Najpomembnejša razlika, ki jo zasledimo med predstavljenima sistemoma organiziranosti patronažnega zdravstvenega varstva je univerzalni model patronažne zdravstvene sestre v Sloveniji v nasprotju z bolj specialistično usmerjenim modelom na Škotskem. Razlike, ki obstajajo, so posledica kulturnih in političnih vplivov v zgodovini. Mnogi avtorji so mnenja, da stroka zdravstvene nege potrebuje oba modela, vendar je potrebno ohraniti ravnovesje med zahtevami stoke in potrebami pacientov.

Ključne besede: družinska medicinska sestra, patronažno varstvo, patronažna zdravstvena nega, vloga patronažne medicinske sestre

LIST OF ACRONYMS

WHO	World Health Organization
FHN	Family Health Nurse
PHC	Primary Health Care
USA	United States of America
ICN	International Council of Nurses
UK	United Kingdom
NMC	Nursing and Midwifery Council
SEHD	Scottish Executive Health Department
CC	Collaborating Centre
EU	European Union
RN	Registered Nurse
QNI	Queen's Nursing Institute
GP	General Practitioner
NHS	National Health Services
CHP	Community Health Partnership
PHCT	Primary Health Care Team
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

1 INTRODUCTION

The Master's thesis will describe the World Health Organization (WHO) vision of the Family Health Nurse (FHN) concept, which has been developed as the result of demographic and political changes, significant health care reforms and changing disease patterns. The vision was determined on the basis of historical events and the documents quoted below. The establishment of WHO in 1948 was crucial for the development of the community nursing service in the world, and consequently also in Slovenia (1). The first European conference on Public Health Nursing took place in Helsinki in 1958, where concepts and new tasks for public health nursing were adopted. The Declaration of Alma Ata which was adopted in 1978 at the first International Conference on Primary Health Care has also had a significant impact on the development of the FHN. The then General Director of WHO, Halfdan Mahler, said (2) "To use the nurse as a major provider of Primary Health Care (PHC) requires no major extension of a function that is implicit in the definition of nursing". In 1988 the first WHO conference on nursing and midwifery in Europe was held in Vienna (3). The Declaration of Vienna, which was adopted at the conference seeking to improve community health, highlights that "Nursing can best fulfil its potential for nursing practice in PHC, especially work in the community" (4). The International Council of Nurses (ICN) (as cited in 5) indicates nursing, as an integral part of the health care system, which encompasses the promotion of health, the prevention of illness, and care of the physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual family and group responses to actual or potential health problems.

The WHO has stressed the nurses' role in public health and sees the need to focus on family health and community health nursing. Within the framework of the HEALTH21 health policy, adopted in 1988, the WHO Regional Office for Europe promoted the FHN model as an approach to strengthening the contribution of nursing and midwifery in Europe (6). Martin et al (7) says that the concept of the FHN is built around the need to address the comprehensive health and care needs of the family as a unit from a community perspective. The role is designed to encourage family-oriented approaches to care as a

vehicle to creating sustainable models of nursing care in the community. This incorporates a range of nursing activities including provision of a population needs assessment, definition of health and well-being priorities within a specific geographical or population grouping, direct delivery of care, and prescribing and coordination of care packages to maintain an individual in his or her family and community. The FHNs have responsibility for the assessment, diagnosis, prescribing, delivery, and coordination of the full range of support and care activities. The FHN role is envisaged as fulfilling many functions already available within health services, encompassing elements which are already part of the role of several different types of nurses working in primary care across the European region (6). The WHO (8) outlined that the FHN would be a significant asset in areas where there was a perceived lack of access to underserved and poorer communities within the European region.

The Munich Declaration 2000 highlighted the importance of the role of nurses and midwives (9), and advocated enhancing the role of nurses particularly in the fields of public health, health promotion and community development (10). Particular attention was given to the principle of establishing and supporting family-focused community nursing and midwifery the context, conceptual framework and curriculum for the FHN. For the implementation of the FHN, a multinational study was initiated. Participating countries in the multi-national study included Slovenia and Scotland as lead pilot country.

In the literature there are several terms that cover community-based nursing – the two most commonly used are Public Health Nursing and Community Health Nursing. To understand the meaning of these terms we need to look into the history of the development of community-based nursing, which can trace its history to England, namely Manchester and Liverpool, and the United States of America (USA), namely New York City. According to Allender and Spradley (11) public health nursing combines nursing science with public health science to formulate a community-based and population-focused practice. Public health nursing is the practice of promoting and protecting the health of populations using knowledge and social and public health sciences. Community health nursing is the application of the nursing process in caring for individuals, families and groups where they live, work or go to school, or as they move through the health care system. Nesbitt (12)

defines community health nursing as nursing that maintains a population focus on community needs in addition to providing direct primary care nursing for individuals and families from high-risk groups and vulnerable communities. Kulbok et al (13) emphasize that by the early 1900s public health nursing roles extended beyond sick care to encompass advocacy, community organizing, health education, and political and social reform. It developed as a distinct nursing specialty during a time when expanding scientific knowledge and public objection to squalid urban living conditions gave rise to population-oriented, preventive health care. Prevention and curative care have been distinct concepts since ancient times. Kulbok et al (13) cites Brainard who says that district nursing evolved as the first role for public health nurses, and Florence Nightingale concurrently professionalized nursing as an occupation. Public health nursing in the USA, United Kingdom (UK), and other countries quickly grew to include working with vulnerable populations in diverse settings including communities, homes, schools, neighbourhoods, and worksites. Community health nurses were seen as having a vital role to achieve improvements in the health and social conditions of the most vulnerable populations. For this reason they must have the knowledge and skills that enable them to work with diverse communities. They emphasize prevention and wellness and must have sensitivity to the groups within the community and respect for its established methods of managing problems. The nurse promotes client responsibility and self-care and uses principles of organizational theory with inter-professional collaboration to secure the health of the population (14).

This Master's thesis describes and compares the organization and system of community health nursing in Slovenia and Scotland. The aim is to examine and compare the advantages and disadvantages of each system, as well as the functions, characteristics, tasks and areas of activity. In order to compare the organizational forms of community nursing work in Slovenia and Scotland, we need to look at the historical developments that led to the present forms of the organization of community nursing. There are significant differences between the role of community health nurses in Slovenia and those in Scotland. According to a review of the historical literature, we assume that the changes in the organization of community health nursing in Slovenia developed under the WHO guidelines, documents and policy framework. In Slovenia, community health nursing is

performed at the primary level of health care, as an independent department or organizational unit in Health Centers (15). In Slovenia a polyvalent form of work in community health nursing has been implemented, which Majda Šlajmer Japelj names »patronage model« (16), and explains that the WHO Regional Office for Europe used the name Patronage nursing model for the purpose of worldwide understandings into the Family/Community nursing model, which emphasizes the importance of the primary function of nurses' activity in the community (17). This term will be used to describe community health nursing in Slovenia. Family/community nursing is a special area of health care, which includes an integrated treatment of individuals, families and communities (18) through psychological, physical and social aspects, while taking into account cultural and personal beliefs in all stages of health and illness. The Slovenian family/community nurse adopts a generic role, and provides services across the spectrum of care; health and social care of the individual, family and community, health care of newborns and women after childbirth at home and nursing care of patients at home (19). Implementation of prevention activities and health promotion, based on the Instructions for the implementation of preventive health care at the primary level (20), is the most important mission of family/community nurses, by which they try to influence people to become active and meet their responsibility for their own health, and motivate them to the extent that they seek to maintain their own health and a healthy living environment, and actively follow current preventive actions.

In contrast, across Scotland there is no universal model in community nursing and over the past years professional role development of nursing has been characterised by moves towards a more specialist and advanced practice, bringing with it a profusion of different job titles (21). McKenna et al (22) argues that the evolution of these nursing specialisms is complex and is the result of history, Government policy, changes instigated by regulatory bodies and changes in nurse education. The system in Scotland comprised eight different specialist nursing pathways within the national regulatory framework of the Nursing and Midwifery Council (NMC) (23), before they started with the FHN project. Therefore it was not surprising that, for some, resolution is seen in the form of a much more generic community nursing role, which is the underpinning core of the FHN role. The Scottish Executive Health Department (SEHD) saw this role as particularly suited to the needs of

Scotland's remote and rural communities (24). Scotland was selected for the pilot project because of its reputation of having a well-established community nurse education and system of practice. Although it was legitimised through recognition by the health authorities and a postgraduate education programme was provided at Caledonia University, the Family Health Nursing model was not fully implemented in practice. According to the various terms mentioned above, which cover community-based nursing, the term community health nursing will be used in this thesis to describe nursing activities in the local community performed by several nursing specialists in Scotland.

2 METHODS

The concept of the FHN was not completely implemented in practice, despite the fact that the pilot study in Scotland was successfully completed. The implementation in other participating countries, which had participated in the WHO FHN multi-national study, is in different phases of the project. The family/community nursing service in Slovenia is designed according to WHO policies and as such has been developing for more than forty years. Since very little has been written about the experiences and development of the family/community nursing service in Slovenia, we decided to present it in the literature review, and compare it with the pilot study, which was implemented in Scotland according to the proposal and policies of WHO. This type of research has not yet been carried out in the world or in our country.

The objectives of the master's thesis are:

1. To describe and compare the systems of community nursing in Slovenia and Scotland
2. To discuss the advantages and disadvantages of the systems of community health nursing in Slovenia and Scotland
3. To compare these systems with the WHO model of the FHN.

In the thesis we have set the following research questions:

1. What is the difference in organization of community health nursing between Slovenia and Scotland and why does this difference exist?
2. Why was the concept of the FHN in Scotland not implemented in full?
3. What was the difference in the implementation of the concept of FHN in Slovenia and Scotland?
4. What was the main problem of implementation of the concept in other member countries?

This master's thesis uses the descriptive and comparative research methods relating to community health nursing in Slovenia and Scotland, and in particular to the development of the FHN as advocated by WHO (25). An extensive literature search related to the objectives of the dissertation was undertaken. It describes the development of the

family/community nursing service in Slovenia and the development of the concept as described in policies by WHO, with an emphasis on the description of the pilot study implemented in Scotland; and provides guidance for further development. The search was conducted from August 2012 to April 2014 using national and international databases, and internal documents of organizations that have made a key contribution to the development of the community nursing service worldwide and in Slovenia.

The literature search was conducted in three parts:

- The basis for the conceptual design of the master's thesis was a review of all WHO policy documents and nursing/midwifery publications relating to community health nursing and family health nursing, which led to the development of community nursing in the world. We did not pose time limits for the publications; the selection criterion for the time of publications was unlimited. With such criteria we attempted to cover the entire history of the development, which led to our conception of the FHN vision. Hereinafter we limited the search to the documents about the multi-national study of FNH and pilot implementation in participating countries, especially in Scotland and Slovenia. For searching the literature, we used the following key words: "primary health care", "public health", "community health nursing" and "family health nurse".
- In searching Slovenian literature the time limitation of the search strategy was a maximum of 15 years. It included published literature in national databases of Cobib.si, Digital Library of Slovenia, Digital Library University of Maribor and browser Google in the Slovenian language, using the search terms: "patronažno varstvo", "patronažna zdravstvena dejavnost", "patronažna zdravstvena nega" and "patronažna medicinska sestra". We found very little written about the development and organization of community health nursing in Slovenia and further research led us to older literature. Because of this we expanded the search, which we previously limited to the material available in the library and computer databases, to internal documents of organizations such as: WHO Collaborating Center for Primary Health Care Nursing in Maribor and Nurses and Midwives Association of Slovenia. We also tried to search in international specialized databases, but did not find any publications. A key document in the Slovenian

literature is "Family/community nursing and family/community nursing care-upgrading and adapting to new challenges" ("Patronažno varstvo in patronažna zdravstvena nega - nadgradnja in prilagajanje novim izzivom") by Šušteršič et al (18), which led us to further literature and from which we obtained information about community nursing organization.

- Scientific and professional articles and publications in English were searched through international specialized databases: MEDLINE, CINAHL, PUBMED, Wiley Online Library, Google Scholar, and Google. The literature search initially focused on the search terms "community health nursing" and "family health nurse" which gave too many results, and led us to exclude resources that were not directly related to the development and organization of community nursing in UK.

Table 1: The number of items identified using the defined search criteria by databases

Database	Number of items
MEDLINE	3078
CINAHL	5998
PubMed	24060
Google	844000
Google Scholar	943000
Google books	282000
Wiley Online Library	139451
Total	2241587

Despite the selective criteria we still got too many sources, so we limited the search only to Scotland. Substantive criteria for the selection of the data obtained were based on three fundamental criteria: i) development of community health nursing, ii) organizational structure of community health nursing, iii) FHN pilot study. This gave us insight into the organization of community health nursing in Scotland and how the implementation of the FHN pilot study was conducted.

Table 2: The number of items identified using the re-defined detailed search criteria by databases

Database	Number of items
MEDLINE	23
CINAHL	12
PubMed	13
Google	41
Google Scholar	7
Google books	6
Wiley Online Library	5
Total	107

3 LITERATURE REVIEWS AND ANALYSIS

3.1 Primary health care – The WHO perspective

The WHO which was founded in 1948 is the primary agency of the United Nations that promotes global public health. The organization plays an essential role in the global governance of health and disease; due to its core global functions of establishing, monitoring and enforcing international norms and standards, and coordinating multiple actors toward common goals (26). Vuga (1) adds that the WHO set up the global health policy and the global strategy for the development of health care in the world. Its establishment was crucial for the development of the community nursing service worldwide, as described at the 1958 Helsinki European conference on Public Health Nursing. The conference adopted concepts and new tasks of health care: prevention and treatment of mental illness, alcoholism, drug addiction and psychosomatic disorders; prevention and early detection of cancer, prevention and control of chronic diseases, occupational therapy, prevention of accidents and disasters, the problem of aging, physiological, psychological and mental rehabilitation, health promotion and education, and care for the sick at home (27).

In 1978 in Alma Ata WHO, together with UNICEF, organized the first International Conference on PHC, where the Declaration on the development and importance of providing PHC by the year 2000 was adopted. The Declaration stresses the need to give priority to the development of PHC in every country, because by providing that level of healthcare the health of all people can be achieved faster. Vuori (28) shows that European countries have differing perceptions regarding the interpretation of the PHC, which suit their political culture. The PHC is a comprehensive health systems approach which is developed in partnership with the communities themselves and it encompasses sectors and activities which influence health and it includes prevention, health promotion, cure and rehabilitation (44). For PHC to be effective, it must be a central function of the country's health system, and integral to overall social and economic development. Vuori (28) points out that PHC could be understood as: a set of activities; a level of care; a strategy for organizing care; and a philosophy permeating the entire health system. It is not a case of

choosing between them, but countries should understand and work with all of them. The Declaration has also made a significant impact on the development of the FHN. All Member States are committed to the fulfillment of the agreement. In addition the European countries are obliged to follow the guidelines of the European Office of the WHO, adopted in 1984, which contain 38 targets needed to achieve the strategic tasks of the European project - "Goals for health all by the year 2000" (1). The main objectives are: to maintain the level of quality of life and provide maximum health care services, thereby increasing people's responsibility for their own health, and educate individuals in terms of strengthening and maintaining health.

More than 20 years ago, in 1988, the first WHO conference on nursing and midwifery in Europe was held in Vienna, Austria (3). The Vienna Declaration (4), which was adopted at the conference, expressed the "need for urgent action by governments and national health decision-makers to help nurses make the changes that are required in nursing if the regional targets for health for all are to be achieved". The Declaration also highlighted that "Nurses should develop their new role by: acting as partners in decision-making on the planning and management of local, regional and national health services; playing a greater role in empowering individuals, families and communities to become more self-reliant and to take charge of their health development; and by providing clear and valid information on the favourable and adverse consequences of various types of behaviour, and on the merits and costs of different options for care. Nursing can best fulfil its potential in PHC when nursing education provides a sound foundation for nursing practice, especially work in the community, and when nurses take account of the social aspects of health needs and have a broader understanding of health development". Changes were needed to improve nurse education, research and practice, to include a concentration on health rather than disease, and a move away from an absolute focus on individuals towards building relationships with families and communities (6). WHO (4) proposed that all basic programmes of nursing education should be restructured, reoriented and strengthened to produce generalist nurses.

Since 1988, Europe has changed dramatically and so has the situation of nurses and midwives (3). Changing demography and disease patterns have challenged WHO

European member states to review the ways in which they deliver health care services. New health problems such as HIV/AIDS have emerged. Non-communicable diseases have reached epidemic proportions in developed and developing countries. Ageing populations and declining birth rates prevail in some member states, and chronic conditions and environmental risks present challenges for most health care systems (29). The modernisation of health services across Europe, where increasing amounts and a greater variety of health care interventions are delivered in primary care and community settings, requires new roles and new ways of working by health care personnel (6).

HEALTH21, the 'health-for-all' policy framework adopted by the WHO European Region in 1998 (8), re-enforced previous WHO commitments to primary care models of health care delivery. HEALTH21 identified 21 targets, ranging from policy level decisions to disease-specific activities, many of which had scope for enhanced nursing input. A core strategy was to promote integrated health service provision, with PHC at its base, and a focus on family and community-orientated care. It highlighted the need to concentrate on public health approaches as opposed to focussing on disease management, and a need for greater professional collaboration in PHC environments. PHC has the capacity to improve peoples' health, by providing the basis of an efficient health system, stimulating community participation and the mobilization of social resources within health policy. HEALTH21 is underpinned by three main values: health as a fundamental human right; equity in health and solidarity in action between countries, between groups of people within countries, and between genders; participation by and accountability of individuals, groups and communities and of institutions, organizations and sectors in health development (6). An article in the International Nursing Review (30) noted that Halfdan Mahler recognized nurses' potential contributions to achieving WHO's health-for-all goal through PHC in his statement when he hailed nurses as a "powerhouse for change".

Political changes and significant health care reforms in the 1990s influenced the Second WHO Ministerial Conference on Nursing and Midwifery in Europe that was held in 2000 in Munich, Germany (31). WHO (31) notes that at the conference, ministers of health and delegations from the European Member States adopted the Munich Declaration: Nurses and Midwives: A force for health. This Declaration is considered one of the most

important European policy documents on nursing and midwifery. It forms the basis of the Nursing and Midwifery programme at the WHO Regional Office for Europe in Copenhagen. In the Declaration, ministers stressed key aspects by which nurses and midwives are a significant political and social force and resource for public health (3). The aim of these strategies is to enable nurses and midwives to work effectively, efficiently and to their full potential as independent and interdependent professionals. The increasing number of people with chronic conditions was identified as the main public health challenge in the countries of the Region. This main challenge was followed by: the means to ensure an adequate workforce of health professionals in the health system, an increasing need for long-term care, adequate funding for health care and the development of a sustainable health care system (3). It also identified the development of key roles for nurses and midwives through: contributing to decision-making at all policy levels; being active in improving public health and community development; and providing family-focused community nursing and midwifery services. As written in the Report (6) part of this on-going development was to support an evidence-base for nursing practice and policy through research, with access to higher-level nursing and midwifery education being essential. International and inter-professional collaboration opportunities were vital to enable nurses, midwives, physicians and policy makers to work and learn together, to ensure more cooperative and interdisciplinary working, in the interests of better patient care. It proposed the FHN to fulfil the need to establish and support family-focused community nursing and midwifery services.

The FHN programme developed out of the recognition that there were significant challenges facing governments in the provision of health care to meet the changing needs of populations across Europe. New approaches to health provision were needed, which included radical changes to existing infrastructures and resources. PHC was identified as an effective means to provide appropriate health services, and has formed the basis of much of the WHO health care development activity over recent decades (8). The Munich Declaration reiterated the importance of the FHN approach within the context of effective primary care. It advocated enhancing the role of nurses particularly in the fields of public health, health promotion and community development (10). The Declaration gave particular attention to the principle of establishing and supporting family-focused

community nursing and midwifery as the context, conceptual framework and curriculum for the FHN. The FHN model was seen as providing front-line health workers, acting as a resource for the public through empowering clients to take responsibility for and make informed choices about their health and wellbeing. It was envisaged that FHNs would work with individuals, families and communities within a defined geographical area. Their activities would cover all age groups, and include health promotion, disease prevention and advocacy, curative care of illness, rehabilitative care, and care from birth to death (25). The importance of this type of work was also recognized by the Chiang Mai Declaration in 2008 which reinforces that countries require galvanizing their communities and professional carers to support people in their homes (7).

Although differences exist across Europe in the delivery of primary care, there is universal agreement that primary care must be the core of service provision and that provision of medical and nursing services based on specialism is unsustainable in the long term. "The workforce has to be prepared in order to have the skills and knowledge to take on new roles and responsibilities. Social and cultural understandings need to be reshaped to accept and support the introduction of new practices" (9). However, the implementation of these principles across Europe has been patchy (28).

3.1.1 The family health nurse concept

Several studies and literature reviews have described the development of the FHN model including a literature review in 1999 undertaken by WHO (6) which provided the basis for the FHN model, through the identification of shared nursing concepts of the family throughout Europe and beyond. It highlighted trends in practice, education and research. A survey of community nursing and midwifery in Europe (32) illustrated variations in educational preparation as well as inequalities in service provision across Member States. It also identified twenty-two different types of nurses working in the community, including School Nurse; Mental Health Nurse; Community Nurse; Public Health Nurse; Home Nurse; Family Health Nurse; District Nurse; Health Visitor; Practice Nurse; Community Nurse (Mental Handicap); Feldsher; Paediatric Community Nurse; Midwife; Occupational Health Nurse; General Practice Nurse; Prison Nurse; Patronage Nurse; Social Psychiatric

Nurse; Palliative Nurse; General Nurse; Labour Health Nurse; Community Chief Nurse (6). In Slovenia, the Republic of Ireland, Finland, Iceland and Latvia, community nurses work as generalists and provide services across the spectrum of care - from illness prevention to curing from the cradle to the grave. Many of the newly independent states of the former Soviet Union are developing generic roles for emerging community nursing services. Health promotion and illness prevention roles in Hungary, Denmark, Norway and UK are undertaken by one nursing discipline, with home care nursing taken on by another. The US has a variety of different models of community nursing both between and within States, with care being provided by private, state and church providers (6).

The FHN programme developed to meet the significant challenges facing governments in the provision of health care, changing health needs demand and new approaches to health provision. The modernisation of health services across Europe, where more health care interventions are being delivered in primary care and community settings, require new roles and new ways of working by health care personnel. Within the HEALTH 21 health policy framework it was proposed that this new type of nurse would make *"a key contribution within a multidisciplinary team of health care professionals to the attainment of the 21 health targets set in the policy."* The full definition of the new role states that "*The FHN will: help individuals and families to cope with illness and chronic disability, or during times of stress, by spending a large part of their time working in patients' homes and with their families. Such nurses give advice on lifestyle and behavioural risk factors, as well as assisting families with matters concerning health. Through prompt detection they can ensure that the health problems of families are treated at an early stage. With their knowledge of public health and social issues and other social agencies, they can identify the effects of socio-economic factors on a family's health and refer them to the appropriate agency. They can facilitate the early discharge of people from hospital by providing nursing care at home, and they can act as the lynchpin between the family and the family health physician, substituting for the physician when the identified needs are more relevant to nursing expertise"* (8).

With the FHN, the WHO Regional Office for Europe has created a role for nurses and midwives that goes beyond the actual roles nurses and midwives have in many countries

(9) and that is in line with PHC and community-based health care policy. The concept was presented as a possible means of developing and strengthening family and community oriented health services within the European region. The starting point was HEALTH 21, where target 15 was noted: "At the core should be a well-trained FHN, providing a broad range of lifestyle counselling, family support and home care services to a limited number of families." A well-trained FHN is a key primary care professional 'who can make a very substantial contribution to health promotion and disease prevention, besides being a care giver' (8). The concept of the FHN was based on community nursing experiences from many countries, especially those of health visitor, district nurse and nurse practitioner models in the UK and the existing FHN model in Slovenia (25). The role and functions of the FHN contain elements that are already part of the role of community nurses working in PHC all over the European Region. What is new is the particular combination of the various elements, the focus on families and on the home as the setting where family members should jointly take up their own health problems and create a 'health family' concept (25). This is what gives Family Health Nursing its unique characteristics (33). In this sense the focus is very much on the practice approach of working with families in a different way and at a different level from existing models. Historically patient care centred on individuals and their health issues and consideration of the family was not integral to the care process.

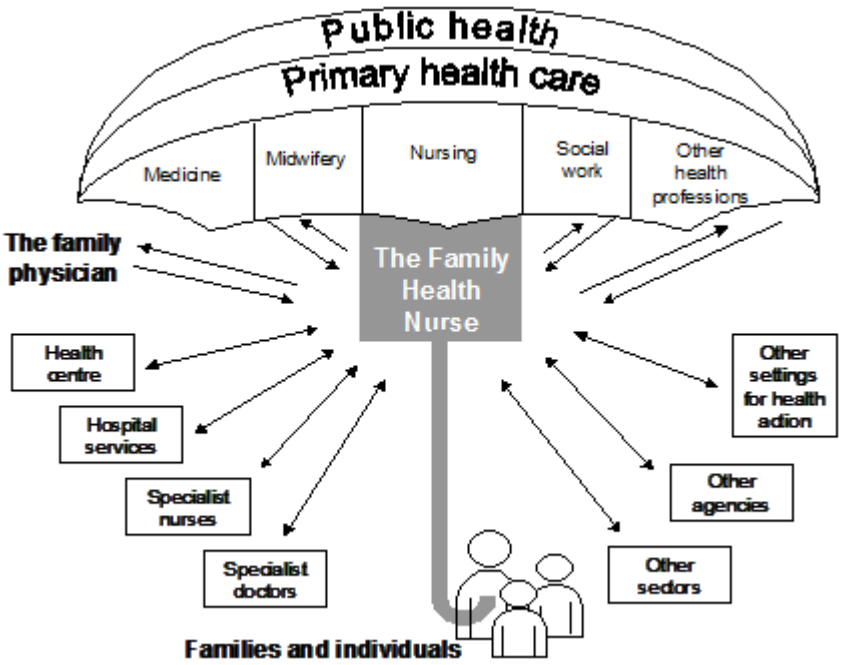
HEALTH21 points out that "families" (households) are the basic unit of society where health care providers will not only be able to address patients' somatic physical complaints, but also take into account the psychological and social aspects of their condition. It is important for PHC providers to know the circumstances in which patients live: their housing, family circumstances, work, and social or physical environment, which may all have a considerable bearing on their illness (8). The FHN concept is based on the idea of the 'family unit', which may include (33):

- Individuals with geographically distant relatives;
- Friends who provide a supportive role in a similar way to a family member;
- A traditional nuclear family, with different generations being geographically close.

WHO (6) sees the approach of FHNs' role to the family as a unit, as a challenge to the users, the nursing profession and other health professions, because traditionally individuals were the focus for health interventions.

The position and role of the new FHN can be depicted, as shown in Figure 1 (25), under the "umbrella" of public health and PHC, and within the context of the integrated health sector described in target 15 of HEALTH21: "By the year 2010, people in the Region should have much better access to family- and community-oriented PHC, supported by a flexible and responsive hospital system."(25)

Figure 1. The Family Health Nurse under the "umbrella" of public health and primary health care(25)



The WHO vision of the FHN was that s/he would be a multi-skilled generalist working as a Coordinator of the different health and social care professions in a multidisciplinary team (6) within home environments, with families, across the lifecycle and within defined geographical areas. As a key professional, together with the family health physician, FHN would give advice on lifestyle and risk factors, assist families with matters concerning health and illness, and take a proactive approach to health promotion, disease prevention,

and early disease detection in the family environment (9). They would work in partnership with families, communities and other health professionals, acting as a health resource, be key health promoters in society and facilitate co-operation between the family, the community and the health care system (6). FHN is perceived to have an important role throughout the course of life, at critical periods and life events, ensuring access to health care for all members of the community. They work in partnership with family physicians, ideally being a family's first point of contact with the health services, and serving as the link between the family and the physician (25, 34).

In the year 2000 a more detailed conceptual framework and curriculum document was developed in order to underpin the impending enactment of the FHN's role (25). The framework (25) draws on "systems theory, interaction theory and developmental theory" in order to bring together the key concepts of family, health and nursing. A curriculum was developed and structured for a 40-week full time equivalent post registration course which was designed to prepare qualified and experienced nurses for this new role. The competencies expected of FHNs cover five major areas: care provider, decision maker, communicator, community leader and manager. The WHO curriculum consists of seven modules using a variety of recognised adult learning approaches, emphasising the use of care scenarios and a family needs assessment process (6). The fourteen detailed case scenarios are presented to "illustrate what might be part of a typical caseload for a FHN" and, in doing so, to aid understanding of the "breadth, depth and scope of their role" (16).

3.1.2 The multi-national study

The WHO Europe member countries were invited to establish FHN pilot implementation programmes appropriate to their health infrastructures. Plans for pilot studies were initiated in order to evaluate the implementation and impact of the FHN model in Europe. In-country evaluation processes were planned, evaluating the development of FHNs, by considering impacts on existing PHC structures, and assessing the outcomes of the FHN programme (9). The outcomes of the study were intended to inform policymakers of the most effective way of developing community nursing and related services. WHO developed the FHN concept, guidelines for its implementation and a curriculum with

which to train nurses as FHNs. The countries were encouraged to participate in the in-country implementations and the multi-national study. That means that each member state was offered the chance to participate based on their ability to meet certain requirements. These included ministerial and local authority support, and the existence of a robust infrastructure to support and sustain the two-year pilot. The aim of the multi-national study was to evaluate the FHN concept, as defined in HEALTH21 and its implementation across different health care systems in Europe (6). Ministerial approval was a prerequisite for being included in the multi-national study, as a means of ensuring commitment and ownership by participating countries. The multi-national study was carried out between 2003 and 2005.

Countries participating in the multi-national study included Armenia, Estonia, Finland, Kyrgyzstan, Lithuania, Republic of Moldova, Slovenia, Scotland and Tajikistan. Denmark, Germany and Spain were interested and remained involved in discussions at a country level. The confirmed countries provided a good representation of member states from Western, Central and Eastern Europe. At the time of the multi-national evaluation, the health systems of the participating countries were all at different stages of development, as were the FHN projects being implemented. Each country has a different health service history, and they vary in their approach to the provision of community health services. Seven countries took part in this evaluation, and twelve participated in the wider processes of the study. Several countries dropped out due to lack of ministerial support or external factors that prohibited their participation. The implementation of the FHN pilot took much longer in some countries and there were differences in the interpretation and realisation of the FHN's role, depending on the stage the countries were at with the development of their welfare policies, infrastructures and practices in relation to community health services (6). As part of the multi-national study a comparative analysis across the region was undertaken by Dr Deborah Hennessy. The most important outputs of the Report (6) show that the initial implementation process, the need for sustainability of the FHN role in practice, the need for on-going research and evaluation to monitor progress, and the importance of FHN education and networking are clear. The interaction between policy, practice and public perception is less clear and requires further investigation.

Scotland was selected as the country to pilot the evaluation tools and guidelines for its analysis (6) and that is why we selected Scotland for comparison of the organizational system of community health nursing in Slovenia. Both of these systems will be presented in detail later on. Detailed analysis of Scotland's participation in the pilot project will be presented in Chapter 3.3.5.

The role of FHN is being piloted in a variety of counties, from countries in transition such as Tajikistan, Kyrgyzstan and Moldova to high-income countries such as Scotland and Germany (6). Although it was initially envisaged that 19 European countries would take part in the development of the FHN role through a parallel process of education and implementation, Scotland was the only country to have completed a pilot project and was far ahead of all other counties in terms of enacting the role (16). Some countries are still in the phase of demonstration or model projects, while others can build upon several years of experience (3).

The main results of the pilot implementation (6) showed that the different and multiple responsibilities that the FHNs have, have caused confusion among users and other health professionals. In addition the focus on a multi-skilled generalist role, within a context of existing specialist roles does pose difficulties with the implementation in many countries. Despite all the difficulties the WHO (9) underlines that the idea of the FHN as the way forward for the development of health care is clearly established. Although the terminology used in the countries differs it does not matter if one calls the nurses FHNs or uses other names in practice; or if the FHN, over time, becomes a transitional role for something else in the future. The concept is robust because all participating countries draw on the ideas of primary care, public health, health promotion and disease prevention as the foundation for the FHN concept.

The European Family Health Nursing Project is a revitalized WHO initiative led by the University of the West of Scotland. Partner countries include Armenia, Austria, Germany, Italy, Poland, Portugal, Romania, Slovenia, and Spain. European Union Lifelong Learning funding was received in 2011 to facilitate a consistent approach to the development of a definition of family health nursing, required core competencies and capabilities, and

consequent education and training requirements (7). The College of Nursing Jesenice is participating in this project. The aim of this project is to develop shared academic and practice based programmes to prepare FHNs in Europe based on an inclusive conceptualisation of the FHN including scope of practice, essential knowledge, and clinical competence across partner countries (35). The University of The West of Scotland was the first in Europe to start an MSc in Family Health.

3.2 The Slovenian health care system and family/community nursing

According to Cibic et al (36) healthcare is a system of social and individual activities, actions and services for improving health, disease prevention, early detection, timely treatment, health care and rehabilitation of sick and injured. Unity of the healthcare system in Slovenia is provided and regulated by The Health Care and Health Insurance Act (37), The Health Services Act (15), statutory regulations and general acts in this area. The Constitution, which lays the foundations of the legal policy, together with the legal regulations and general acts of health institutes, provides the legal basis for the provision and implementation of healthcare (38). Healthcare in Slovenia is regulated on the basis of the Bismarck model of healthcare based on the principles of the statutory compulsory public insurance. The compulsory health insurance scheme covers the whole population, either on the basis of employment and self-employment or residence (insured persons and their family members) specified by law to the Health Insurance Institute of Slovenia. The compulsory insurance does not, however, ensure coverage of all costs that arise in treatment. Complete coverage of costs is provided only for children, schoolchildren and for certain diseases and conditions.

The National Healthcare Programme of the Republic of Slovenia (39) identifies the following development priorities of healthcare:

- policy of health,
- reducing inequalities in healthcare for the population,
- changing patterns of behaviour that are harmful for health,
- a quality living environment,

- encouraging professional development and improving the quality of healthcare,
- health protection research.

Healthcare in Slovenia is provided through the public health service network, which also includes private service providers on the basis of contracts and is entirely comparable with the level of health care in the advanced countries of Europe. The Health Services Act (15) states that the public health service network is determined specifically for primary, secondary and tertiary levels, with the main principle of equal access to necessary services for all users. The network is defined by the content and range of activities provided at the individual level, human and other resources required to provide certain contents, and the spatial distribution of providers. Important principles in determining the network are also the number, age and social structure of the population, opportunities for the use of health services, the degree of urbanization, specificity of the settlement, etc. The network of public health services at the primary level consists of geographically defined areas, each of which must themselves provide comprehensive health services at the primary level. This area may be a municipality or group of municipalities or gravitational area Health Center. Criteria for the establishment of a public health services network are defined each year by the General arrangement and regional arrangements as adopted by the Government of the Republic of Slovenia (40). Healthcare service includes actions and activities through knowledge and technology performed by health professionals and health workers. The Slovenian national program of healthcare (39) states that we prioritise a health policy, whose goal is that all Slovenian citizens have ensured healthy growth, physical and mental development, remain healthy as long as possible and have the ability to work. The content and provision of healthcare services are regulated by The Health Services Act (15) and carried out at the primary, secondary and tertiary levels. A public health services network at the primary level is defined and implemented by the municipality or city, and services at the secondary and tertiary levels are provided by the state.

The Slovenian health care system has been well described by Česen (41), who says that Slovenia has a good organizational and functional structure of the healthcare system that works satisfactorily and does not require major revolutionary changes. Changes are necessary only in terms of adaptation to the economic, political and demographic changes

within the country itself and the countries of the EU. He points out that this will be achieved through various activities in many areas, towards which the health policy must aim, that it enhances people's care and responsibility for their own health, family health and employment. Premik (42) adds that from the perspective of health policy a broader assessment of the needs is required, which covers problems in areas such as health care services, health promotion, social care and environmental protection. Česen (41) suggests that health policy needs to pay more attention to healthcare at the primary level and to prevention, instead of mainly dealing with healthcare services at the secondary and tertiary levels.

With the adoption of the WHO Declaration of Alma Ata more than thirty years ago, the State Council decided that its health policy should focus on PHC (43). The Declaration of Alma Ata (44) viewed PHC as the basis for healthcare reform, offering a framework for essential and universal healthcare provision for individuals, families and communities, based on »practical, scientifically sound and socially acceptable methods and technology«. The Government of the Republic of Slovenia (45) states that PHC services are organized at local level, such that they are equally accessible to all people without discrimination, with assured, continuously accessible urgent medical attention and emergency services. Cibic et al (36) defines PHC as the protection of individuals, families and communities in the area where people live, work and attend school, which is carried out by the health care system and all other social factors outside the health care system in the area. Basic health care is provided by the state, the central function and central part of the health system of the country. It is the most important driving force of healthcare, and an integral part of social and economic development of the country, spreading from the periphery towards the interior. The basic component of PHC is primary nursing care. Primary nursing care of the healthy and the sick is a broad concept of nursing and represents the most extensive care for the health of individuals, families and communities (1).

A fundamental component of PHC is health promotion (46), which enables people to take shared responsibility and care for their health and become active participants in efforts to improve it. The Ottawa charter (47) highlighted that: "Health promotion focuses on achieving equity in health". Hoyer (46) believes that by making health education part of a

general education the highest possible level of health education, motivation and responsibility for one's own health will be achieved. She continues to explain that the purpose for this is to prevent disease by detecting and preventing risk factors. The target groups of health education at the primary level are the people who lead healthy lifestyles or are exposed to low or average health risks (46). The mission of health professionals in PHC is to cooperate and integrate with other health and social-welfare, educational and other institutions, enterprises, organizations and individuals, to design and implement programs for strengthening, maintaining and restoring health (15). Sancin (48) points out that, when deciding on the content, scope and work, public participation is necessary. The involvement of policy is essential because PHC is a political issue, and for strengthening and maintaining health it is necessary to set social and political objectives. The Resolution of the National Health Care Plan of the Republic of Slovenia (49) states that health is becoming an integral part of all policies, especially the financial, working and transport policy, environmental protection, agriculture and food production, education, sport and social activities, making the most of all the areas and maintaining health as a value.

According to Zaletel-Kragelj (50) PHC includes care for adequate food, drinking water, housing conditions, environmental protection, health self-protection, protection of mother and child, family planning, emergency situations care, and the supply of medicines. In addition to other functions specified by The Health Services Act (15), PHC also includes home visits, nursing care, treatment and rehabilitation at home. The primary level of health care is accessible to all people at the local level without prior referral or intervention of other healthcare institutions. Healthcare services at the primary level are organized locally and include basic medical and pharmaceutical services, which are undertaken by Health Centres, health stations and healthcare workers with private contracts. PHC services are provided through the municipalities, which own the Health Centre and employ all the staff, including nurses, according to the staff standards for PHC and pharmacy in a PHC services network. For the provision of health services at the primary level, the Act of Institutions (51) defines Health Centers as public institutions. Česen (41) notes that the Health Centre is qualified for the functions of integrated preventive and curative health care. It is a center at the primary level of health care and the major public health achievement of the last century. The operation of the Health Center is in the public interest. Štemberger Kolnik

(52) emphasizes that PHC treats the patient as a person with all the problems, fears, feelings and insecurities at the heart of the healing process, bringing together all relevant health information and preventing fragmentation of the health process. Česen (41) states that "In the Health Centre people get comprehensive preventive and curative health care in one place." According to Klančar et al (43) the fundamental mission of the Health Centre is coordination of prevention and health promotion, and therefore Health Centres would become a modern integrated social-medical centre, in accordance with the guidelines of the new centre for health promotion, with emphasis on self-preventative health concerns. It should become the center of health-education activities at the local level.

In The Health Services Act (15), family/community nursing is described as an activity of PHC organized in the context of the Health Centers, or as an independent service of private healthcare providers. Šušteršič et al (18) cite various authors, who say that family/community nursing is a special form of health care, which offers active health and social protection to the individual, family and community that, due to biological properties or certain diseases, are particularly sensitive to environmental influences. These arguments are in accordance with the definition of community health nursing as described by the WHO (44). The Strategy for care for the elderly by the year 2010 (53) mentions family/community nursing as a specific form of health care in the home of the insured person and in the local community. Health promotion programs must be developed within a specified health care area to encourage the elderly to better care for their own health and the health of their families. Family/community nursing has an important place in the management and coordination in the current organization of health and social care, which older people need, most often in a combination of services.

Family/community nursing has specific procedures and interventions, which cover all areas of healthcare for individuals, families and local communities and operates in the following areas of health:

- maintaining and improving health,
- prevention of diseases,
- assisting in the early detection of disease,
- helping in treatment and implementation of health care,

- assistance with rehabilitation (18).

Family/community nursing has the objective of allowing the early independence of everyone in the local community, regardless of whether they live in the family or alone, have their own home, are homeless or marginalized, in performing their basic life activities.

Family/community nursing care is an integral part of primary, active nursing care for the health of individuals, families and communities at home (36). Family/community nursing care includes health promotion, preventive and curative activities, health care of the chronically ill and disabled, palliative care and rehabilitation. Stražar and Šušteršič (19) underline that continuity, professionalism and effectiveness of achieving the objectives of family/community nursing care depend on the expertise of employees, relationships (family/community nurse – patient – family - community), the development of and qualification for team cooperation and work sharing, professional supervision, as well as on the motivation for the implementation specificity of family/community nursing care. Family/community nursing care is mainly performed by family/community nurse, who is a Registered Nurse (RN) with university professional education and/or specialization in family/community nursing, which covers the following areas of work: health and social care of individuals, families and communities; nursing care during pregnancy, puerperium and newborns at home and home care of patients. Šušteršič et al (18) identifies a nurse with specialization in nursing or faculty education as a leader in family/community nursing. In some country areas the family/community nursing service includes also the healthcare assistants, which perform nursing care at home under the guidance of family/community nurse. Healthcare assistants are usually based in a family physician outpatient clinics, and do not attend patients at home. In addition, psychiatric nurses and stoma nurses also provide care programmes in the community on an outreach basis, but are directly linked to secondary care services.

The family/community nursing care covers the following areas of work (18):

- health-social treatment of individuals, families and communities,
- nursing care of puerperium and newborn at home and
- nursing care of patients at home.

The health-social care of individuals, families, communities, and nursing care of puerperium and newborns at home rank among preventive activities, while nursing care at home ranks among curative activities (54).

The health-social treatment of individuals, families, and communities represents the implementation of general, special and individual tasks of family/community nursing. The general task includes professional work preparation, identification of health and social needs, planning and implementation of nursing interventions, evaluation, recording and documenting the work performed and results achieved (55). The specific tasks vary and depend on the profile of the patients treated, and individual task are implemented according to the basic needs and problems of the patient, which requires specific treatment that involves the immediate and wider environment. The implementation of preventive activities on the basis of the "Instructions for the implementation of preventive health care at the primary level" (20) is one of the most important functions of family/community nursing, which states that the work of family/community nursing services focused primarily on the treatment area as a whole, as well as on the treatment of individuals, families and communities in their habitat. The mentioned Instructions (20) comprise:

- six home visits of newborns and infants in the first year, and two additional visits for the blind and disabled mothers of newborns;
- one home visit of a child in the 2nd and 3rd year of age;
- two home visits per year for the blind and visually impaired people with additional disabilities aged 5 to 25 years if they are in home care;
- one home visit for pregnant women;
- two home visits in the puerperium;
- two home visits for people over 25 (patients with active tuberculosis, muscular and neuromuscular diseases, paraplegics and quadriplegics and patients with multiple sclerosis and cerebral palsy, people with learning disabilities, disabled people, patients with chronic diseases and people up to 65 years of age);
- programmed health education in the family and local community groups.

The family/community nursing covers the activities of midwifery nursing, which includes prenatal, perinatal and postnatal nursing care at home (56). Midwives are mainly employed

in the birth rooms, maternity wards and hospitals. Nursing care during pregnancy, puerperium and caring for the newborn is one of the oldest forms of community nursing in families, and is one of the priorities of health care, because pregnant women are among those categories of the population, that require special attention because of their sensitivity. The family/community nurse is an important link in the chain of services responsible for the birth of a healthy baby and its normal development in a biosocial environment (57).

Nursing care at home is a narrower field of nursing care, which is intended for the sick, injured, disabled and helpless patients and represents family/community nurse assistance for the patient to perform basic life activities. It also involves developing and maintaining contact and a relationship of trust with patients, interpreting of their needs, desires and priorities (58). This is a curative activity and therefore requires the order of work to be issued by a family physician for all nursing interventions and procedures in nursing care (59). The frequency of curative home visits and the duration of nursing care depend on the patient's condition and their socio-economic potential. In situations like this the nurse in family/community nursing must obtain an even higher degree of autonomy when deciding on priority nursing problems, which will certainly lead to a higher quality of the services provided (18). Depending on the patient’s health status and type of nursing interventions, caring for the patient at home may also include specialists such as physical and occupational therapists, self-therapist, health technicians, sometimes even employees of the Centre for help at home, volunteers, Hospice and others (59). Nursing care at home is also inseparably connected with social care. The integrated approach of the family/community nurse adds extra weight to social care at home, because it is often crucial that they enable patients to be treated at home. If we want high-quality patient care, the basic conditions for them to stay at home (arranged apartment housework assistance, general and personal care, social support) should be fulfilled. Various forms of voluntary help are also very important because they have an important role in ensuring less demanding forms of care and support at home. However, volunteers cannot be a substitute for professional performers. The purpose of their help is to provide human contact and proximity, household assistance, encouragement and support for the elderly or the sick, support for caring tasks and often relief of family members.

Zavrl Džananović (60) points out that preventive and curative activity in health care complement each other, because of their holistic approach to individuals, families and communities through psychological, physical and social aspects. In view of this, the implementation of activities should be equally distributed and therefore the curative component should not exceed a sixty percent share of the work performed. Demographic changes, development of medical science, amended treatment of patients in hospitals and reducing the tendency hospital stay periods, are all factors that have a direct impact on the increasing range and content of nursing home care (61). Since 1984 the share of preventive nursing care has been slowly but constantly decreasing, while the proportion of curative nursing care has been increasing. Zavrl Džananović (60) notes that currently family/community nurses carry out three times less preventive work annually, than dictated by professional guidance, because most of their working time is spent performing nursing care at home. The above mentioned Instructions (20) are listed norms, which should be the basis for planning health care for adults. The target rate should be 1650 people or 515 families per family/community nurse, an intermediate rate of 2500 people and 780 families and the crisis rate of 3000 people or 930 families. Since 2006 the ratio is one family/community nurse for 2500 people.

Although the family/community nursing service is an independent unit of primary health care, and plans the preventive activities independently, the “working order” from the patients’ family physician for performing nursing home care always takes priority. Because of this the rights of beneficiaries of preventive visits, which are guaranteed by law (20) are violated, and thus the preventive activity, which is the original purpose of family/community nursing, is reduced (61). Zavrl Džananović (60) argues that the reduction of preventive work in community nursing may also affect the discrepancy of documents that discuss and define the scope of prevention programs. For many years the payer have not paid for the prevention program as specified in the Instructions for the implementation of preventive health care at the primary level (20). Šlajmer Japelj (17) notes that it is alarming to find that in practice the family/community nursing service is no longer the same as it was adopted and presented in the world, but in about 80 percent of the time has become a "service activity", which has led to a loss of autonomy. The author adds that it is precisely the autonomy of the profession which enables high quality nursing care.

In order to achieve better results, changes are needed in health policy and health systems. Documents between the Ministry of Health and the Health Insurance Institute of Slovenia regarding the content and scope of prevention programs and the financial ability for preventive home visits need to be harmonized (18). The decision regarding the number and scope of preventive visits should be in the domain of the family/community nurse, because they are the most familiar with the situation and the needs of patients in each family and local community. Horvat (62) adds that at a time when in the developed world nurses undertake certain tasks from doctors in nursing patients with chronic disease, in Slovenia family/community nurses do not have the competence to decide on nursing care at home. In response to the resulting changes, in 2006 the family/community nursing profession issued the document "Family/community nursing and family/community nursing care-upgrading and adapting to new challenges", which describes the theoretical guidance of the family/community nursing operation and staff regulations in relation to the occupational group.

3.2.1 The historical development of community nursing in Slovenia

Maria Theresa was the first person in Slovenia who advocated that the practice of nursing knowledge was necessary, and established the first midwifery school in Ljubljana and Klagenfurt in 1853. In 1860 Florence Nightingale founded the first school for nurses at St. Thomas Hospital in London, and is credited for the establishment of the scientific basis of nursing and the foundations of the nursing profession. The Nightingale experience spread from the UK to other European countries, so that her contemporaries also existed in countries such as The Netherlands and Sweden (27).

An important role in the development of nursing in Slovenia is certainly assigned to Angela Boškin (born 06/06/1885, died 28/07/1977), who graduated in 1918 in Vienna as a "qualified professional to carry out social welfare activities in all areas of public nursing care", (63). She began her pioneering work in the field of nursing at a time when the nursing profession was recorded for the first time by the National Government of the Republic of Slovenia, and whose Department for Social Welfare in 1919 issued a decree about setting up the first "caring sister" (64). Her work, which was monovalent (for better

understanding we shall use the term “specialist”), focused on the protection of mother and child and the anti-tuberculosis activity in Jesenice. She was the forerunner of today’s family/community nurses and social workers (27). Angela Boškin was also co-founder and longtime president of the first professional association of nurses in our country, founded on 27th November, 1927. At the same time dr. Andrija Štampar, organizer of health care in Zagreb, was working in Yugoslavia. He presented the position of the community nursing activity as one that was intended to focus on socially and health vulnerable population groups. The first school for the professional education of nurses ("School for sisters’ assistant") was founded in Belgrade in 1921, followed by a school in Zagreb, and in 1924 a School of “protective sisters” in Ljubljana (27), which was originally of a specialist type, but became polyvalent (for better understanding we shall use the term “generalist”) in 1931 (65). After the Second World War, by renaming the “School of protective sisters” to the “School of nursing”, and with the exit of charitable ecclesiastical orders from the hospital environment, the title of nurse began to be asserted (66). Majda Šlajmer Japelj (17) summarizes the historical development of the community health nurse with the words: “Nurses, who worked in the local community before World War II, were initially called "caring sisters". Soon after their activity with the content of the educational program was more clearly defined, they were renamed "protective sister", which actually defines their function in relation to society. The title of “patronage nurse” came into use after the Second World War, which in a foreign language presents the same content of nurses' work in the local community - particularly health protection.”

Andrija Štampar supported the work of nurses and enabled them to gain access to overseas education. Zagreb nurses performed generalist community services, which combines health and social work (59). Following the example of generalist community services in Zagreb, services also started to operate in Belgrade, unlike Slovenia where specialist community nursing still operated within the Health Centers (27).

During the Second World War community nursing work was abandoned, and after the war, health care focused on reducing infant mortality, tuberculosis and trachoma. Fieldwork was then performed by non-expert nursing care workers, especially members of the Red Cross. At this time the community health services had not kept pace with the general health

services, which caused a delay in the development of the service and its preventive activities. Thus, the activity was split and remained without a plan and common base.

The concept that the family is an invisible whole was established slowly, and from the beginning of 1953, centers of generalist community service developed in Yugoslavia including Zagreb, Belgrade, Ljubljana, Maribor and other cities around the country (27). In 1956 the Yugoslavian Act of Health Centers was published, which organized community nursing centers. The centers employed both community health nurses and social workers. After that, due to large human and material possibilities, community services began to receive an increasing scope of work, and became ever more important and more efficient.
Vuga (27) argues that the establishment of the WHO in 1948 was of great importance for the development of the community services, and that dr. Andrija Štampar, co-founder of the organization, influenced a more efficient expansion of community nursing in our country. Priority was given to outside hospital treatment, uniform health policy and health promotion. He also participated at the WHO Europe conference on Public Health Nursing in Helsinki in 1956 and transferred the directions for community nursing formed at this conference.

Nurse Cita Bole, organizer of the community nursing services in Slovenia, and participant in UNICEF, the United Nations International Children's Fund, established in 1946, in her paper "Community Nursing Service in Slovenia" (67) signaled the need to integrate midwives into the community nursing service (59). Midwives became involved in the operation of generalist community nursing services in Health Centers in 1971 as a professional midwife unit. The work was undertaken by midwives and nurses specialized in gynecological - maternity nursing. In 1954 the first edition of the pioneering professional journal "Community nurse" appeared, primarily intended for nurses in community nursing services, and was edited up until 1961 solely by its editor Cita Bole. The journal was the forerunner of the journal "Health Review", which was first issued in 1967 and in 1994 renamed in the "Slovenian Nursing Review".

The authors Belič and Bole (67) describe the community nursing services in the 60s as patchy in different branches of health care. They used to operate in outpatients clinics for

women, children and anti-tuberculosis dispensaries and outpatients working clinics, which resulted in a plethora of different profiles in the same family. Therefore, the Nurses Association of Slovenia began to advocate holistic treatment of individuals, their families and communities, taking into account the physical, mental and emotional components of their environment. The association supported distribution of the work area to urban districts, so that in a certain field, all work in connection with the community nursing service was performed by one community nursing worker in order to allow continuous treatment of individuals and families in their home environment. They suggested that the community nursing service become an independent professional unit in Health Centers, which would include all community nursing workers dealing with planned protection of wife, mother, baby, small child, schoolchild and adolescent, the patient and the older person. Thus the community nursing service was arranged according to certain professional branches and individual problems grew into organized care of the family. As a result of this, in 1962 the Institute of the Socialist Republic of Slovenia for Health Care adopted the first professional instruction for the organization and operation of community health nursing, which contained the definition, purpose, functions and objectives of community health nursing (59). In 1971 the community nurses of Slovenia issued an "Elaboration of the family/community nursing services" (68) through the Nurses Association of Slovenia, whose objective was to include as much as possible the needs of families, functions of midwives, social workers and nursing care at patients' homes in community health nursing. The Act of Health Care from 1974 legalized the community nursing service with all its activities, so that the formerly specialist home care service, became generalist with midwifery care and patient nursing care at home (59). In 1975, a Professional group of nurses and healthcare assistants in community care was founded with the aim of study professional issues in the field of family/community nursing and family/community nursing care; organizing training in all areas of nursing and related sciences, the contents of which were important for the progress of the profession; standardizing methodology and procedures in family/community nursing; and providing development and progress in the profession (69). Although it lasted for only for a short period, in that time, family/community nurses were competent in issuing the orders for nursing procedures. A "work order" from the patients' personal physicians was needed only in cases of medical and technical interventions (69). This means that the decision-

making regarding their work was completely autonomous. At the conference in Alma Ata in 1978, the declaration regarding the development and importance of PHC through the "Health for all by the year 2000" strategy was accepted. Member States, including Yugoslavia, were committed to ensuring such a health policy that would contribute to the achievement of the broadest campaigns of health care in the world by consolidating PHC in their own country (1).

Silva Vuga has certainly played an important role in formulating the family/community nursing profession. As a family/community nurse, together with her professional team she set the foundation of the method of the nursing process in family/community nursing (69). The method of the nursing process was put into practice in 1986 based on a pilot study, which took place from 1981 to 1986. In 1990 the pilot study on nursing diagnoses was also undertaken, which was incorporated into daily practice in 1994 (59).

On the initiative of the WHO Regional office for Europe, the Collaborating Center (CC) for Primary Health nursing established in Maribor in 1986, which has played a very important role in the development of nursing as a profession and the organization of family/community nursing services as we know it today. CC was established on the basis of an agreement between the State - Member State of the WHO and the WHO. The tasks of the CC are based on EU directives, WHO documents and national needs, and are related to nursing care, namely in the field of PHC, which is a multi-disciplinary collaboration in caring for the conservation and protection of the health of individuals, families and communities. The CC in Maribor is one of six European centers engaged in the areas of nursing care in primary health, and was established especially because of the complete organizational and substantive family/community nursing service and nursing care at patients' homes. Since the Slovenian family/community nursing service operated within the generalist protection of families long before this approach became one of the methods of work in primary care in Europe, it can serve as a model for other countries (70). The author (17) adds that family/community nursing services have always been concerned with the implementation of prevention and health promotion of the individual, the family and the community, completely autonomous and independent from the family health physician. The first ten years of CC were extremely important for the formation of nursing as an

autonomous profession, and for the integration of Slovenian nursing care with the international professional community. The preparation and edition of the Small lexicon of terminology in terms of nursing (36) and the implementation of the nursing process as a work method in a care team, are two of the most important tasks performed by CC in cooperation with the Nurses and Midwives Association of Slovenia, because they have enabled a rational and logical relationship in the profession and were, and still are a bases for its growth and quality (71). Šlajmer Japelj (70) explains that a professional team of community nursing services has produced, tested, and put into practice a model of generalist community nursing, which includes the nursing of sick people at home. This was upgraded a model of "continuous nursing care" which was tested, and provides continuous monitoring of patients and the essential link between home and the health institutions where they are admitted, which eliminates any inequalities in their access to health care services. The CC actively participated in the preparation of the First European conference on Nursing and Midwifery in Vienna in 1988 and later in the realization of accepted tasks in Slovenia. It is also actively participated in the preparation of the Second WHO Ministerial Conference on Nursing and Midwifery in Munich in 2000. The participation between the Regional office and CC is associated with the realization of the Munich declaration and treatment of the material of the European health policy "Health 2020", which emphasizes the role of public health and the need to strengthen PHC (72). Filej (73) emphasizes that change in the social system in the early nineties brought about changes in health care as well as the new health law in 1992, which is based on the principles of the WHO - Health for all by the year 2000. With a new concept new roles and tasks of nursing were defined, which the profession must implement as an integral component of health care. For the successful introduction of the set tasks and to improve and protect professional interests The Nurses Association of Slovenia became The Nurses and Midwives Association of Slovenia in 1992. Its mission is to strengthen the role and importance of nursing profession in Slovenian and international space, for the purpose of maintaining and ensuring the status and reputation of members in nursing and midwifery professions. In 2007, The Regulation on Licensing of Nursing and Midwifery Providers was adopted, which maintains a register of nurses and midwives, and ensures the safety and quality in nursing and midwifery care.

3.2.2 Formal education development

In 1924 the first secondary school for nurses (pre-registered) "School of nurses at the Institute for Social and hygienic protection of children in Ljubljana" was established in Ljubljana, and was of the specialist type (65). The first graduate students of the school, including Angela Boškin, received the title “children's protective sister”. They began work on social hygiene in child protection, health education of the adult population and working with physicians in counseling services and dispensaries (66). In 1927, the school was renamed "School for child protective sisters," and in 1931 “School of protective sisters”, which was generalist (65). Dragaš (cited in 63) says that the purpose of the school was to educate nurses in the field of protection of infants and young children, youth protection, consulting and professional child care, cribs, daily protection, kindergartens, homes for the protection of youth, vulnerable, abandoned and neglected, protection of the sick, orphans, the poor and those suffering from tuberculosis. Protective sisters worked in offices and organizations for the protection of youth in the countryside, in other districts, to control the health and social status of all family members, and cooperated with all authorities of social - hygienic protection of children (66). In 1949 candidates completed a three-year programme in the renamed “School for Nurses in Ljubljana”, which was later extended to four years. Meanwhile the "School for Nurses in Maribor" was also founded. With the law on the establishment of higher medical schools in Slovenia the school in 1954, was recognized as a college and renamed to the “Nursing College Ljubljana” (65). The first nurses graduated in 1954 and became responsible nurses as well as teachers of nursing in higher and secondary schools (63). The Act on establishing of higher health schools (74) states that the mission of the Nursing College was to train students "theoretically and practically for leadership of nurses in healthcare institutions and their departments, for self-management of minor health institutions, for working in community nursing and for the instructors of the middle and lower medical staff". The aim of study at the higher professional level was to give nurses the broad basic knowledge in order to become successful, sovereign and independent workers at all levels of health care and to encourage and assist individuals, families, social groups to achieve optimal health potential within their given life chances. From 1953 onwards the school organized a post-graduate course for nurses already employed in community nursing to upgrade their knowledge and to

inform them about innovations in medical science in terms of prevention (75). Belič and Bole (67) describe that from the perspective of education of community nursing staff, the school mainly provided practical work in community nursing, but with a lack of knowledge of the fields of social etiology and social pathology, psychology, pedagogy and basic legality of the social relations that are much needed for the operation of the community nursing service. The next turning points happened in 1962 when the college was renamed the College for Health Workers, and in 1993 when the College for Health Workers became the College of Health Studies and switched to a higher professional educational program lasting six semesters. The most recent change happened in 2009 when the college was transformed into the "Faculty of Health Studies". Graduates with the title RN became generalist nurses. They were expected to successfully perform quality health care focused on helping individuals, families and communities in all states of health and disease. According to the ICN (76): "The scope of preparation and practice enables the generalist nurse to have the capacity and authority to practise primary, secondary and tertiary health care competently in all settings and branches of nursing". The advantages of generalism were well described by Castledine (cited in 77) who said that "Generalists usually maintain a wide variety of competencies and, in particular, are able to co-ordinate, manage and lead a nursing team. Their skills are based on the fundamentals of holistic nursing and continuity of patient care, they support the "essence" and "fundamentals" of nursing care and provide a more flexible workforce (77). The author also enumerates the disadvantages of generalism including the fact that nurses cannot keep their knowledge up to date across a whole field of nursing practice leading to poorer quality of care for particular patient groups and a dilution of clinical skills.

In 1970 the college organized a post-graduate education in the form of specializations or courses that lasted one or two semesters such as courses of intensive care, psychiatric care, and occupational medicine. In 1994 and 1995, the school organized a post-graduate professional education for nursing managers from the University Medical Center and Institute of Oncology. According to Zaletel (63) the study programs have changed and been upgraded according to the needs and development of the nursing profession and other sciences, and also in relation to a wider social policy, which hasn't always supported the profession.

Since Slovenia entered the European Union (EU) nursing care became recognized as one of the important regular jobs, allowing for large movements in the field of education (78). However, there has been a need for the harmonization of nursing study programs with other European nursing colleges and the harmonization of Slovenian legislation with EU directives. Differences can be found among EU member states, depending on the school system as a whole, and the traditions and the organization of social partners. Today study programs are evaluated with credit points, which enable students to move from university to university within the country and in the EU. The Bologna Declaration was adopted in 1999 with the aim of reducing the differences between the educational systems of States parties, through an action plan, based on the promotion of student mobility and employability, and the objective of increasing the international competitiveness of European education (78). Since 2008, there is the possibility of continuing studies at the Bologna second level (master's programs) and in the future, at the third level (doctoral programs). Železnik et al (78) points out that with Slovenia's accession to the EU nursing care was given the status of an independent scientific discipline.

With changes in national pathology (an increase in the number of elderly people, chronic patients, and greater social distress) the need for nurses with additional specialist knowledge has increased, because the "universal nurse" no longer meets the requirements of clinical practice. Starc et al (79) notes that the knowledge of nurses needs to be upgraded to provide direct specialized, complex and consequently safer patient care. According to ICN (80) "specialisation entails the application of a broad range of theories to selected phenomena within the domain of nursing, in order to secure depth of understanding as a basis for advances in nursing". The nurse specialist is a nurse prepared beyond the level of a generalist nurse and authorised to practice as a specialist with advanced expertise in a branch of the nursing field (76). The ICN documents (81) also talk about the Advanced Practice Nurse, defined as: "A Nurse Practitioner / Advanced Practice Nurse is a RN who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A Master's degree is recommended for entry level".

The recent Organization for Economic Co-operation and Development-OECD study »Nurses in Advanced Roles: A description and evaluation of experiences in 12 developed countries« (82) show that the taking on of more and more complex duties and tasks in nursing care also required an additional postgraduate degree. In most European countries work is performed by RNs with a bachelor's degree or master's degree in nursing, in some areas even by nurses with a specialization. Both cover the nurse's interventions beyond competencies of RNs trained as general nurses (79). The development of specializations in nursing care is known in many EU countries and conducted in cooperation with EU directives as a general higher education for nursing care (89/48 EEC, 92/51/EEC, 1999/42/EC), but the exact course of specialization in Slovenia has not yet been determined (79). In 2009 the Nurses and Midwives Association of Slovenia received final opportunity for granting public authority for planning specializations and the implementation of specialized exams in the field of Nursing and Midwifery (83). Since then a draft entitled "Regulation of specializations of Nursing and Midwifery providers" was prepared, which has not yet been confirmed by the Ministry of Health.

Since 2004 until recently, the Faculty of Health Sciences Maribor has provided the following specialist courses: gerontological nursing, family/community nursing, informatics in health and nursing care, perioperative nursing, and clinical dietetics. However, due to lack of interest by employers, more were not subscribed (84). Specialization took place on the initiative of the WHO CC Maribor, whose principal mission is Family nursing care. At that time the director of the CC Tatjana Geč, member of WHO Europe, participated in the preparation of a curriculum for FHN, which served as the basis for specialization in family/community nursing.

3.2.3 The current role of the family/community nurse

The family/community nurse, as defined by Geč (85) is a healthcare professional who assists individuals and families to maintain health, overcome disease, and help the chronically ill and people at risk by attending to them in their homes and in the local community. The code of ethics for nurses and medical assistants Slovenia (86) states that nurses are trained to satisfy the needs for nursing care, health education, work

organization, as well as research and development activities all within their competence. The family/community nurses plan their work daily, monthly and yearly on the basis of (54):

- the number of biological or risk population groups - children (newborns, infants, babies and preschool children, schoolchildren and a teenagers), women (pregnant women, puerperium, infertile women and those in their postmenopausal period), the disabled, the elderly, and patients;
- socio-medical indicators of the health status in a certain area - a snapshot of the geographical area, municipality, region: vital statistics (births, deaths, stillbirths), health statistics (morbidity, trauma, absenteeism), demographic statistics (population, age structure and sex);
- hygienic-epidemiological characteristics of the area: registered hygienic problems (drinking water, smog, disposition of waste water);
- epidemic disease (lice, scabies, a contagious inflammation of the liver);
- sporadic disease;
- characteristics of local area (urban, geographical, economic, cultural);
- experiences from previous years.

The entire process of the family/community nursing treatment involves the individual, the family and the community (87). According to Šušteršič et al (18) the individuals being treated by a family/community nurse include women (pregnant, postpartum, puerperium, women in the fertile period and menopause), children (newborn, infant, baby and pre-school children and primary and secondary school students), adults (employees, patients with chronic non-communicable diseases, inhabitants of large cities and industrial centers etc.), the disabled, the elderly and socially disadvantaged groups (refugees, gypsies, the homeless, etc.). The family/community nurse must in addition to the implementation of general task also participate in the diagnostic programme, therapeutic programme, and health education (18).

Šušteršič et al (18) emphasize that in the provision of health and quality of life of individuals, the family and society play an important role, because their parentage network represents a specific socio-cultural institution, which is connected to their social

relationship and individual freedom in a specific way. Lupša (88) points out that the objectives that a nurse's efforts in the family aim to achieve include regulated socio-economic conditions, a healthy trained family, a calm and communicative environment, good relationships in the local and wider environment, and a satisfied function of the family. The family/community nurse, who advocates and uses a family approach, can use their knowledge and sense of empathy to include wider circumstances of health problems and assist the patient and family that are looking for a way to improve their health. Šušteršič et al (18) note that since the family/community nurse meets various forms of family in their work, they, must be familiar with the different developmental periods in the family cycle, such as: newlyweds, the birth of the child, families with schoolchildren and adolescents, starting a new family, empty nest families and elderly families. At different periods different problems may appear. According to Šušteršič et al (18) in order to take action professionally, they must be familiar with the characteristics of the developmental periods, the most common health problems, social and existential questions and Maslow's hierarchical scale of needs, modified for the family, which include: (a) basic needs for survival and physiological needs, (b) safety and security, (c) love, affection, loyalty, (d) respect, and (e) self-realization. Many people live in groups that cannot be classified into any of the aforementioned families, but the functions performed are the same. All groups are faced with problems faced and the ways they try to solve them are similar to those in the traditional families (89). Therefore the family/community nurse treats all groups as family. The treatment of human relationships within the family requires expertise, tact, sensitivity and teamwork. Rajkovič and Šušteršič (54) say that on the basis of this data, the family/community nurse together with the family, identify the situation and conditions in the family, plan, implement and evaluate nursing care, while at the same time maintaining a dynamic balance in the family and their quality of life. Šlajmer Japelj (17) adds that even though the family structure changes over time, it is of strategic importance that the family/community nurse functions as a family nurse, because the focus of her work is precisely in the family, at a given time and in a given environment.

Šušteršič et al (18) says that health of the community is the common achievement of the highest level of physical, mental and social health, which is consistent with the attainable knowledge and resources within the community. The implementation of the WHO strategy

"Health for all in the 21st Century" (8) plays an important role for nurses, particularly in the local community. Geč (85) points out that for qualitative work in the local community it is important to know the geographical area, the various factors in the local community, population, network of assistants, health problems of the local community and solution possibilities. This means that the family/community nurse working in the local community is a direct connoisseur of health and social problems in a particular area. Her work is primarily focused on preventive activities and health education training of the population, for which she decides on the basis of the epidemiological and social image in a particular community. The aim of treatment is to reduce the health and social issues and change individual behavior for a better and higher quality of life. The family/community nurse carries out work in the local community in the form of lectures, workshops and work in small groups. Majda Šlajmer Japelj (17) argues that the family/community nurses have a very important role in the local community, because besides their duties as family/community nurses, they also function as members of various working groups and bodies in the field of social health care, which represents a significant support of their work and function within the local community.

As mentioned above the family/community nurse participates in all areas of health promotion and prevention, works in the local community, organizational, environmental and public health policies, as well as economic and legal education (90). Šušteršič et al (18) emphasize that by promoting health, the family/community nurse encourages people to put health in first place on the list of human values, actively care for it and have more of an impact on the economic and social effects on health. They are involved in the implementation of preventive work within the framework of CINDI (Countrywide integrated non-communicable disease intervention programme) Slovenia. The CINDI program was created in 1984 in response to the ever growing and difficult to manage chronic diseases and risk factors, especially unhealthy lifestyles in the European region and in response to the fourth goal of the strategy WHO Health for All by 2000, which is to reduce the burden of the most common chronic non-communicable diseases: cardiovascular disease, cancer, chronic obstructive pulmonary disease, diabetes, and mental disorders (50). On the basis of the contract between the WHO and the Ministry of

Health of the Republic of Slovenia, CINDI has developed and implemented programs for the prevention of chronic non-communicable diseases.

The family/community nurse, according to Šušteršič et al (18), is the coordinator of all forms of assistance at home, and the connection between the individual and their family physician, to whom she reports about the health status of the patient and the situation in the family. She coordinates the work in the nursing and medical team, and also collaborates with other health teams depending on the specifics of the patient (whether it be a newborn, an infant, a pre-school child, a school child, an adolescent, a healthy or sick adult, a disabled or elderly person), with health services at secondary and tertiary level and with other departments and organizations outside the Health Center, which can in any way contribute to the optimal solution of the situation for the individual and family. The function of the coordinator is also defined in the "Instruction on the provision of social treatment" (91) in cases of discharge from the hospital, and cases where the patient lives alone.

The purpose of family/community nursing teamwork is nursing care directed towards the individual, family and community, with the aim of achieving optimal health. According to Šušteršič et al (18) the family/community nurse as a team member works with colleagues and shares their experiences, advice and knowledge. The nursing team involves nurses with university professional education, specialists for family/community nursing and healthcare assistants who are involved in the implementation of nursing care at home (92). The nurse is a provider of nursing care in the nursing team, which enables and supports the process of health nursing and at the same time, provides a basis for professional responsibility (93). The aim of the nursing team is the patient, who, although independent, is actively involved in treatment. All team members must participate in the process of continuous nursing care, and each team member carries a certain amount of responsibility to help solve the problem/s (88). Therefore, for good co-operation among the members of the nursing team it is important to have a good interpersonal communication that enables high-quality health care, and professional as well as personal growth of each team member. The medical team in family/community nursing is an interdisciplinary team not only consisting of experts from various professional and scientific fields such as physicians of

different specialties, the family/community nurse, nurses from various clinics and dispensaries, and health assistants (88), but when necessary, also of other professionals, such as social workers, occupational therapists, physiotherapists, clinical psychologists and other professionals who work in the community. The structure of the team adapts to the needs of the individual patient and his family. Team members with their skills and knowledge contribute to the common goal of finding the best treatment and solutions for the individual.

3.3 The Scottish health care system and community nursing

According to The Commonwealth Fund report the UK's health care system is one of the most efficient in the world. The UK has a government-sponsored universal healthcare system provided by National Health Services (NHS). Each of four countries England, Northern Ireland, Scotland and Wales, have their own system of publicly funded healthcare and since political devolution in 1999 each country has full responsibility for health care, and each country has different policies and priorities which have resulted in a variety of differences existing between the systems. Since devolution in 1999 a number of distinctive policy developments have influenced the practice of health, education and social services within Scotland. Changes in the structure of the health service, a refocusing on public health and the development of policy pertaining to social justice have led to the introduction of a programme of initiatives at grass-roots level that attempt to develop services and annexe previously uncharted health ground (23). Healthcare in the UK and Scotland is publicly funded, that is free at the point of need, being paid for from general taxation. There is a small private healthcare sector in which healthcare is acquired by means of private health insurance, as part of an employer funded healthcare scheme or paid directly by the customer, but this covers only selected non-emergency service (94).

Scotland has a variety of population profiles ranging from densely-populated urban areas to remote, sparsely-populated and relatively inaccessible areas, which demand differing approaches to healthcare provision (95). Healthcare in Scotland is mainly provided by Scotland's public service – NHS, created in 1948 at the same time as those in Northern Ireland, England and Wales, incorporating and expanding upon services already provided by local and national authorities as well as private and charitable institutions. The NHS in Scotland is part of the UK NHS, but has always maintained a distinctly "Scottish" approach to health policy and service delivery. The NHS encompasses a variety of different services, which can broadly be divided into: public health, primary care, secondary care, and tertiary care (96). The main legislation providing the legal framework for the NHS in Scotland is the National Health Service (Scotland) Act 1978 (96). Responsibility for health and for health services rests with the Scottish Cabinet Secretary for Health, Wellbeing and Cities Strategy, who is accountable to the Scottish Parliament. Many of their functions are delegated to 14 integrated territorial NHS boards responsible

for planning and delivering all health services – acute, primary and community – to the population in their areas. There are also nine national health bodies responsible for services that are best provided by a single organization, such as ambulance transport, information, education and training, and quality improvement (97). Regional NHS Boards are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services. All NHS Boards work together for the benefit of the people of Scotland and work closely with partners in other parts of the public sector to fulfil the Scottish Government's Purpose and National Outcomes (97). NHS boards directly employ on a salaried basis the staff working in hospitals and the community. They also manage, through Community Health Partnerships (CHPs), the contracts of independent contractors in primary care such as family physicians (in UK used term general practitioners (GPs)), dentists and community pharmacists, reimbursing them for the work they do for the NHS. CHPs are the key mechanism for planning and delivering primary care and community based services (96).

Social care services are a shared responsibility between the local NHS and the local government's Social Services department, and falls under the guidance of the Department of Health (94). Payne (98) note that the Social Work (Scotland) Act 1968 form the basis of community care regulations, together with the amendments of the Community Care and Health (Scotland) Act 2002 and Delivering for Health 2005. The 1968 Act places a duty on local authorities to assess community care services for those who are in need, and placed the organisation and provision of welfare services with social work departments, while the 2002 Act introduced changes to the delivery of residential and non-residential care services in Scotland (98). The Healthcare Quality Strategy for Scotland (99) provides the basis for the people who deliver healthcare services in Scotland to work with partners and the public towards three Quality Ambitions and a shared vision of word-leading safe, effective and person-centred healthcare. This vision and the focus on quality healthcare is the context for all strategic and operational decision-making across NHS Scotland. Since the launch of this document, the Scottish Government announced its ambitious plan for integrated health and social care and set out the 2020 Vision and Strategic Narrative for achieving sustainable quality in the delivery of health and social care across Scotland which describe the challenges for health and social care for the future and provides a commonly agreed

narrative about the direction they are working towards. The 2014 Health and Social Care Integration Act (100) bring these aspirations into law. The aim of community care is to enable people to live for as long and as independently as possible in their own homes, or in the community. The most significant document, Delivering for Health (101), sets out the policy infrastructure to create a fundamental shift in the way the NHS works, from an acute, hospital-driven service to one that is community-based.

Primary care, operates within the geographical boundaries of individual NHS Boards, is normally the first point of contact for information, and has been established to improve the health of their local population, to work jointly with a wide range of partner agencies, to commission hospital and community services and to develop primary and community care services (94). Primary care refers to the services provided by health professionals in either clinics or practices, or sometimes in a patient's home (96). Service is mainly provided by GPs, which were able since 1990s to become fund holders who could purchase a limited range of services from NHS trusts on behalf of their patients (97). GPs are independent and contracted by local NHS Boards to provide their particular service, and their contracts are negotiated on a national basis. GPs normally work together as partners in a local practice and are responsible for employing their own administrative and practice nursing staff but the team also includes NHS employed community nursing staff such as health visitors and district nurses (96). The UK never adopted key concepts of PHC as defined in Alma Ata Declaration. Therefore, hereinafter we will use the term primary care to describe the health activities in primary level performed by several health professionals.

Nursing in the community as a broad and wide-ranging concept in Scotland has undergone a modernisation programme over the past 10 years. Many different community services which incorporate nursing care have been developed, and can take place in settings that range from small community hospitals/doctor's surgeries to work in peoples' homes (16). There are three major types of providers of nursing services in the community: NHS Scotland, independent sector providers and providers of occupational health services. NHS Scotland directly employs RNs and healthcare assistants who work in the traditional community nursing disciplines of health visiting, district nursing, school nursing, community psychiatric nursing and community learning disability nursing (21). The

national nurse staffing levels in the community are typically captured as either a ratio (e.g. number of district nurses per 1,000 head of population) or through average caseloads (i.e. patients seen per district nurse or per community based RN) (102). Macduff (16) explains that caseload is a list of people receiving professional intervention for health or illness related matters, which usually includes summary details of why they are being seen and how frequently.

The current system comprises nine different specialist nursing pathways in community as additional post registration qualification, which is recognized by the NMC as the qualification entry to district nursing, health visiting, general practice nursing, and occupational health nursing. Other specialist nurses working in communities may have expertise in the care of people with specific diseases (e.g. Macmillan Nurses for cancer care; Diabetic Specialist Nurses). McKenna et al (22) emphasizes that the recent policy shift from acute hospital care to community care has brought with it an increased number of community-based specialist nurses. McKenna et al (22) says that evolution of these nursing specialisms is complex and is the result of history, Government policy, changes instigated by regulatory bodies and changes in nurse education. This diverse array of professionals has evolved in an attempt to meet the health care demands of varied populations. However the community nursing workforce in the UK is frequently criticised as being over-specialised and fragmented to an extent that may be dysfunctional not only for the professions, but also for the public whom they serve (103).

The Better Health, Better Care – action plan (104) presenting the desire for a model of nursing in the community that delivers effective nursing support to individuals, families and communities within community services that are proactive, modern, safe and which help people to realise their potential for health and well-being (105). The Review of nursing in the community in Scotland, Visible, Accessible and Integrated Care (21) highlighted that some elements of the nurses role in the community are less effective, can be done equally well by other practitioners, and are not well understood by individuals, carers, colleagues in the multi-disciplinary, multi-agency team and even fellow nurses. The FHN project has challenged this approach by exploring the feasibility of preparing a generalist community nurse who can work across these professional boundaries (16). In

2012 The Modernising Nursing in the Community programme (106) was established to provide support and direction for community nursing to realise its full potential in providing safe, effective and person-centred care and support to people in Scotland. The eight Career and Development Frameworks for Community Nursing have been developed in partnership with NHS Education for Scotland by community nursing discipline specific groups; public health nursing, district nursing, nursing in occupational health, general practice nursing, community children's nursing, health protection nursing, community learning disabilities nursing, and community mental health nursing (106).

3.3.1 The historical development of community nursing in Scotland

Mason et al (107) who describes the community care in Scotland say that the provision of care by Scottish communities since pre-industrial times evolved to its more formal and institutional culmination during the modernist thrust of the twentieth century. Since then, major changes have occurred within the delivery of health and social care, particularly over the last twenty years. The enactment of the NHS and Community Care Act (108) in post-modern times was the beginning of a political endeavour to respond to economic, demographic and professional pressures about the welfare of its citizens within their own communities. An explicit aim of these community care reforms is to maintain people within their own homes whenever possible. Family members and the development of other community agencies are therefore important service providers.

In the late 1990's the three main community specialism: district nursing, health visiting, practice nursing, felt under pressure and were suffering crises of identity. District nurse role has been affected by the community care reforms in early 1900's with dividing health from social care, and leaving many district nurses lamenting the loss of holistic care for patients and their families (109). Also health visitors were concerned about their role, when health authorities make different demands for health visiting services with increasing a range of public health programmes. In the contrast of these roles, practice nurses were the main beneficiaries; they develop their role in managing chronic disease and health promotion. However, many of them felt uncomfortable that GPs were dictating the boundaries of their practice (110).

The NMC was established under the Nursing and Midwifery Order 2001 (111) in 2002 as the successor to the UKCC and the four National Boards for Nurses, Midwives and Health Visitors for England, Northern Ireland, Scotland and Wales. The main functions of National Boards were to monitor the quality of nursing and midwifery education courses, and to maintain the training records of students on the courses. NMC was required to establish and maintain a register of qualified nurses and midwives which has three parts to the register for nurses, midwives, and specialist community public health nurses. A part of the register for specialist community public health nurses was established because the NMC took the view that this form of practice has distinct characteristics that require public protection (112). Health visitors, school nurses and occupational health nurses are currently registered on this part of the register. Since then NMC is responsible for regulating and assuring the public of safe, effective nursing and midwifery practice in the UK (113). Many district and community nurses feel that they have been let down by their professional associations and trades unions, who they believe have failed to provide the vision and professional leadership required (114). Robotham (115) says that as a result of the Register submission many nurses have lost a special name, and thus feel the loss of an identity. It seems appropriate to explore whether nursing is a profession and how specialist community public health nursing has developed into a specialism that is sufficiently separate from nursing to require a separate entry in the professional register. Prior to the advent of the new register, nurses, midwives and health visitors working in the community adhered to the roles that had, by custom and practice, been assigned to the job title (115).
Further in this chapter, the historical development of district nursing and health visiting are described separately, because they were developed separately in time and content.

District nursing

District nursing represents one of the earliest home visiting services and it has developed as one of the most prominent in the public perception of community nursing (116). The district nursing service traces its history to the 19th century sanitary reform movement in England, which established most of the legislation and institutions that are the basis of the UK health care system even today (117). Previously nurses, whether employed in hospitals or in private homes, were frequently uneducated and often had no formal training. In the

1840s nursing sisterhoods were founded to improve standards of nursing in Britain in emulation of the Catholic nursing orders on the continent. One of these was St. John's House, an Anglican Nursing Sisterhood founded in 1848. In gratitude for Florence Nightingale's achievements during the Crimean War, 1854-1856, a fund was raised by public subscription to enable her to found a training school for nurses. This was the Nightingale School set up at St. Thomas' Hospital in 1860. Florence Nightingale assisted in organizing district public health nursing, where each nurse was assigned a specific geographic area of London and was responsible for the health of the people living in that neighbourhood. Other hospitals, both voluntary hospitals and workhouse infirmaries, established their own training schools, many with superintendents trained at the Nightingale School (118).

The start of district nursing in the UK is usually attributed to William Rathbone, a Liverpool merchant and philanthropist, who employed a nurse called Mary Robinson to care for his dying wife and was so impressed by her work that after his wife's death he continued to employ her to look after he "poor sick" in the surrounding area (117). With Florence Nightingale's advice Mr Rathbone started a training school to prepare nurses for work in people's homes. The school supplied nurses for the district to work for both the needs of the hospital, and for private care. These pioneer district nurses were seen not only as nurses of the sick, but also as social reformers. For administrative purposes, Liverpool was divided into eighteen districts based on the parish system and so the nurses became known as "district nurses" (119). By May 1863, district nursing associations soon spread to other cities, including Manchester, Leicester and London. In Scotland, Glasgow became the pioneer location of district nursing in 1875. Florence Nightingale viewed district nurses as promoting environmental sanitation and teaching the family health promotion and disease prevention self-care practices (120).

The most significant development came in 1887 when the Queen's Nursing Institute (QNI) was founded with a grant from Queen Victoria's Women's Jubilee Fund (117), for the education of nurses to tend the sick poor in their own houses. The Institute ultimately became responsible for the whole of district nursing services and became nationally and internationally recognized, and the title of Queen's Nurse became synonymous with a high

quality service (119). In Edinburgh, the training and supervision of Queen's Nurses began in a Central Training Home and later at Castle Terrace until 1970, when it was transferred to Queen Margaret University. The name of the Institute was changed to the 'Queen's Institute of District Nursing' in 1928 and to the Queen's Nursing Institute in 1973. Nurses have not trained at the Institute since 1968, but the Institute continues to support community nurses in any specialty with project funding, professional development, information networks, financial and personal assistance, and works to influence national policy affecting nurses in primary care (114). In 1900 the main aim of district nursing was to provide nursing care for the sick poor. The district nurse role expanded in the early decades of the twentieth century in response to changes in society brought about by the First World War, and the state registration of nurses 1919. In addition to their intimate work with the sick, district nurses were increasingly to be found as community midwives, in mother and baby clinics, visiting schools and assisting GPs with major and minor surgery at home (119). Until 1948 district nursing was organized in a system of voluntary local associations, many of which were affiliated to the QNI and adhered to their standards of practice and system of supervision. After World War II the working condition of district nurses began to alter, significantly affected by changes in medicine, technology, organisation and social attitudes, and this continued throughout the subsequent decades (116). The next major change came with the advent of the NHS in 1948 when local authorities became responsible for the provision of a home nursing service and when health care became free at the point of access. Before that the very poor and old age pensioners were generally nursed for free. Since then home nursing was paid for by everyone through National Insurance contributions and the nurses were employed by local authorities until 1974, when responsibility was transferred to the new NHS health authorities (118).

From 1948 the district nurse cared for anyone and everyone under the provisions of the NHS, but with the nursing care becoming solely the province of the nurse and progressively less intervention coming from the GP (116). Most district nursing services were organised on a patch basis. During the 1960s and 1970s the concept of the Primary Health Care Team (PHCT) – in which community nurses are attached to a GP practice – gained widespread favour. The organizational pattern known as "attachment" is defined by

Department Of Health and Social Security as “a system which enables nurses, health visitors, and midwives to work in partnership, with GPs, proving medical services and preventive services to the population they serve, defined not by a geographical district but by patients on the GP’s lists” (121). They were ‘attached’ to one or more GP practice and exclusively responsible for the patients on the list of specified GPs (122). These patients may be geographically dispersed and the idea of a district nurse being a well-known figure in the local community has now largely disappeared. The Audit Commission (123) has called it an image from the past. “Liaison " was defined as this type of responsibility combined with that for a traditional geographical district. Walker and McClure (122) note that it was hoped that attachment arrangements would encourage the development of a more efficient and comprehensive primary care service based on principles of professional collaboration and teamwork. With this way of working nurses lost the concept of the community. For example in inner-city areas, a qualified district nurse may work for several small practices (123).

In the 1970s few district nurses, except in very remote areas, combined nursing with midwifery, school nursing, or health visiting, so that the nurse’s work in rural areas was no longer so dissimilar to that of the urban district nurse. By the late 1970s and 1980s developments in community health policy were also beginning to force a number of fundamental changes in role, workload, and working day or routine, constantly redefining the nurse’s job description and changing the relationship with other health care professionals. District nurses may no longer be as autonomous as they were previously, and much of that original work has been takeover by specialist nurses such as community psychiatric nurses, stoma-care nurses and Macmillan or Marie Curie nurses. With changes in hospital nursing practice, including shorter inpatient stays, district work is considered by some to have become proportionately more fulfilling. (116).

Although the mentioned health policy developments in 1990s were not aimed directly at the district nursing service, changes have affected the way and type of care that district nurses deliver (124). It has also drawn a distinction between health and social needs, which identified district nurses as the key professionals in assessment of health needs, and social workers as the key professionals in assessment of social needs (125). Within the

framework for the NHS in Scotland, Delivering for Health (126) was published, which set an opportunity for district nurses to take a lead in developing home based nursing services for older people (127). In 2009 The QNI has issued the report 2020 Vision: focusing on the future of district nursing (119), which draws on the history of district nursing to identify the core values and skills of nursing in the home, and visualizes the role of district nurses of the next decade.

Health visiting

Baldwin (128) says that development of health visiting, from a historical perspective, is also important for community nursing. The main focus of activity was in Manchester, where the Manchester and Salford Sanitary Association was formed in 1852, and a branch of the Ladies' Sanitary Association in 1861 (121) in response to the high infant mortality rate in the poorer districts. Prior to that, woman were working in similar roles, to promote healthier lifestyles and counteract the high rates of infant mortality, but often in a voluntary capacity (128). Florence Nightingale was also responsible for the first programme of education for health visitors, and for promoting its spread. Adams (129) notes that the first health visitors employed by a local authority developed from the role of ladies' sanitary inspector and were known as 'sanitary visitors'. These workers' role, like that of health visitors today, was primarily to promote health and to provide health education, working at the level of the infant, their family and the community. They were expected to visit all mothers as soon after a baby's birth as possible, to advice on hygiene and infant care. Their duties were also being extended to include visiting pregnant women and children until they reached school age. During the 1890s the chief focus of the health visitor's work was environmental health and the control of infectious disease (121). Clark (121) adds that health visiting at that time was quite distinct from nursing, although the majority of health visitors were RNs, and a nursing qualification had been required in Scotland since 1932. The Royal Sanitary Institute began overseeing qualifying courses for health visitors in 1916, with the first statutory qualification for health visiting established by the Ministry of Health in 1919. From 1925 the Ministry of Health took over responsibility for training health visitors, and a midwifery qualification became a requirement before entering

training. It was only after 1945 that nursing registration became necessary in order to practice as a health visitor (129).

The Second World War also brought some changes for health visiting. Through the 1950s and 1960s the emphasis of the role of the health visiting shifted towards the all-purpose family visitor (121), which meant that preventive and social aspects of health visiting were re-established, with more attention paid to the family as a unit (130). Health visiting became a universal statutory service in 1929, through the Local Government Act, and health visitors were employed by local government until 1974, when their employment moved to the NHS (129). In 1959 health visitors role expand in preventing the break-up of problem families, the care of the elderly in their own homes, the home management of handicapped children, and prevention of mental illness (121). The Council for Education and Training for Health Visitors in 1977 published four principles for health visiting practice: search for health needs; stimulate an awareness of health needs; influence policies affecting health; facilitate health-enhancing activities (128). Although they have been revisited several times since, they continue to underpin health visiting training and practice. A century and a half ago, improving sanitation and reducing infectious disease were the priority; today it is addressing the antecedents of chronic disease, particularly mental health (129). Public health became a national focus from the 1990s and also became a major component of the role of health visitors, who was expected to work with individuals, to be the lead nurse for safeguarding children and lead on the delivery of the healthy child programme. In 1994 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) introduced proposals for the future education of community health care nurses, where the title of health visitor was changed to “Public Health Nurse” in anticipation that this would encompass a broader function (130). In 2002 health visitor regulation, along with the regulation of all other nurses was transferred from the UKCC, which was replaced by the NMC a regulatory body whose title did not include the phrase “health visiting”. Since then health visitors are registered as “specialist community public health nurses” (128).

3.3.2 Formal education development

Florence Nightingale was one of the pioneers in establishing the idea of nursing schools. In 1860, with the public subscriptions of the Nightingale Fund, she established the Nightingale Training School for nurses at St Thomas' Hospital. Her intention was to train nurses to a qualified and specialized level, with the key aim of learning to develop observation skills and sensitivity to patient needs, and then allow them to work in hospital posts across the UK and abroad (131). Her influence flourished and nursing is now a course taught at most British universities. The University of Manchester was the first English institution to offer the course at degree level. As was mentioned before, on the initiative of William Rathbone Liverpool Infirmary provided the first training courses for district nurses in 1863. By the 1870s it was clear that better training was needed to address the skill and competence required to work in the community. By establishing of The Queen Victoria Jubilee Institute for Nurses was set the standards for district nurses training to be delivered across the four countries of the UK by different district nurse associations (132).
The first Register of Nurses was established by the Nurses Act 1919, where can be traced a record of the specialisation in pre-registration education (77), which was performed within the framework of training schools in general and specialist hospitals. Several European countries had the same kind of specialised pre-registration education, but on the initiative of the Vienna and Munich Declaration (4, 10) had moved to the generalist qualification. Clark (77) notes that UK is now the only country in the world that does not train a generalist nurse at the point of initial (basic) registration. The Project 2000 (133) represents a kind of compromise that a Common Foundation programme lasting two years, followed by a one-year Branch Programme. The programme was for four branches; mental health nurses, learning disability nurses, children's nurses and branch for care of older people. After the adoption of Project 2000, nurse education moved into universities while continuing to have a close relationship with nursing practice, largely in the NHS (134). Thirteen years after Project 2000, Fitness for Practice (135) suggested that the rationale for this level of specialisation should be re-examined in the light of changing health needs and that review should consider a range of options including a redefinition of branch structures and generalist nurse preparation (77). Lord (134) stresses out that the greatest impact on nurse education, however, came with Making a Difference: Strengthening the Nursing,

Midwifery and Health Visiting Contribution to Health and Healthcare (136). This report was part of the evidence considered by the UKCC when compiling Fitness for Practice (134), which stressed the need for stronger links between universities and the NHS. The promised review Fitness for Practice and Purpose (137) outlined six possible models of pre-registration education, but the issue has still not been resolved.

Since the time of Florence Nightingale, it has been recognized in the UK that community nursing requires specialist post-basic education, and training programs for both district nurses and health visitors (117). Clark (77) in her document about specialisation in nursing summarized its advantages as: depth in knowledge in the specialist field improves the quality of patient care, patient outcomes, and patient satisfaction; greater job satisfaction; increased status and recognition and disadvantages as: fragmentation of patient care; challenge to the basic nursing value of holism; deskilling of the non-specialist professionals; inappropriateness for people with multiple pathologies. Regarding to the training of district nurses various changes were made, and in 1981 a mandatory training was introduced in the NHS (132). Up until 1990 most nurses working in the district nursing team were either RNs who had undertaken training to enable them to gain district nursing qualification or State Enrolled Nurses who had also completed a community qualification (138). In 1994 the publication of the Post-Registration, Education and Practice report was published, where specialist nursing practice was defined (139), also the Community Specialist Practitioner Qualification was introduced, and in 2001 the UKCC published Standards for Specialist Education and Practice which Institutes of Higher Education had to incorporate within the degree programmes (140). These standards identified eight community pathways with district nursing called “nursing in the home” as one of them (132). The others are: general practice nursing, community mental health nursing, community learning disabilities nursing, community children’s nursing, public health nursing/health vising, occupational health nursing and school nursing. The UKCC (141) proposed that all post-registration professionals could obtain a specialist practitioner qualification once they had completed a programme of study at university degree level. Therefore, having passed academic examinations and undertaken supervised placement, a generalist nurse could become a specialist nurse, even though they might not have had a great deal of experience in the particular area of practice (22).

There are probably four domains of nursing: general, specialist, higher level or advanced and paramedical (142). Currently, nursing is a three-year undergraduate course in the UK, with students choosing the branch they want to study from day One e.g. adult, child, mental health, learning disability, or combinations of two (called dual-field). The course consists of a balance between course work in classes and practical placements in a health care setting. Nurses are prepared in one of four branches to work in hospital or community (139). Newly qualified nurses then have to register with the NMC in order to apply for jobs and legally practice. After their registration many nurses develop a sub-specialist field of interest and pursue their careers as a specialist nurse (138). All courses in the UK conform to the EU Directives for nursing 2005 (143).

Since 2000s there are in Scotland nine Universities providing education for nurses and midwives who are working or seeking to work in primary care. The courses offered range from short courses with a specialist focus to Master's Level degree programmes. The curricula pertain to those degree programmes which combine an academic award with a specialist practice qualification. Thus curricula were obtained from the five Universities in Scotland offering community based degree programmes with specialist qualifications across the following areas of practice:

- General practice nursing,
- Community mental health nursing,
- Community learning disabilities nursing,
- Community children's nursing,
- Public health,
- Health visiting,
- Occupational health nursing,
- District nursing,
- Family health nursing (103).

The new public health nursing programmes in 2000s have been developed concurrently with, but separately from, the FHN project. They have involved a revision of the pre-existing health visiting courses to combine health visiting and school nursing. The new Public Health Nurses have recently started to practice in Scotland. Other specialist nurses

working in communities may have expertise in the care of people with specific disease (e.g. Macmillan Nurses for cancer care; Diabetic Specialist Nurses). Midwives are also active in UK communities, caring for women through pregnancy and childbirth (103).

3.3.3 The current situation in community nursing

In Scotland, there is a strong tradition of nurses providing services in the community, faced with many current and future challenges (101, 144), especially nursing roles are changing in response to increasing patient and population needs, staffing pressures and the introduction of new ways of team working (95). Macduff (16) underline that an extensive range of role titles is currently used in nursing to describe the many different functions performed, educational standards attained and qualifications achieved by nurses. Some titles are well established and were founded prior to the NHS, while others have developed more recently. Many community nurses believe that their field of nursing is the most challenging and satisfying because of great range of practice and the professional autonomy (117). The Prescription of Medical Products by Nurses Act 1992 also gave certain community nurses the authority to prescribe selected drugs and dressings from a nursing formulary. Traditionally many community nurses based in rural regions have combined several roles to meet the health care needs of a diversity of clients across geographically widespread areas (16, 33).

Savage and Kub (145) say that a starting point for understanding the role of the nurse in public health is to examine the role of nurses who have the title of public or community health nurse and to look at the key activities they engage in related to promoting the health of populations. Nurses in the community are ideally placed to carry out health assessments and preventative interventions (101) with the aim of helping individuals to identify any circumstances which may have a negative impact on their long-term conditions and support them to develop strategies to avoid them or reduce their effects (21). Whitehead (146) underlines that all nurses have a part to play in improving the health of local people and it is the responsibility of all nurses to incorporate health promotional and health education activities into their professional roles.

Nursing in the community is based on trusting relationships with clients and an in- depth knowledge of the local population. Individuals and their families value the relationships formed with nurses in the community, which are based on mutual respect, trust and rapport. It is through these relationships that nurses are able to make accurate holistic assessments and negotiate strategies for promoting health improvement and enabling self-care, helping people to achieve maximum health and well-being outcomes (21). They are educated to see the whole person and to see individuals within the context of their communities and culture. However, nurses also need to articulate how their roles and relationships contribute to the support of service users and carers. Like other members of the profession they must demonstrate an inviolable respect for persons and communities, without prejudice, and irrespective of race, orientation and personal, group, political, cultural, ethnic or religious characteristics (112). The confidence in nursing is founded on the enduring values and behaviours which demonstrate excellence in nursing (147).

Community health nurses are key members of the interdisciplinary team needed to meet the demands of public health today, which requires staff not only to work in partnership but also to break down boundaries by providing integrated care within health and social care teams and participating fully in health impact assessment (148). They also link with a wide range of other professionals which helps them to work more effectively with service users, improve service delivery, and achieve better partnership working (95). Team structures should support the development of strong professional working relationships among nurses, GPs and those working in local authorities and the independent sector and must have the capacity to include unpaid as well as paid carers (21). Hampson (149) note that when group attachment was introduced in 1960s, it was thought to allow better communication between the professional groups than when nurse work in geographical patches. Sweet and Dougall (116) adds that this new system was viewed as successful in developing the concept of the community health team into workable reality where family care was comprehensive and those providing it were professionally supported. Over the last thirty years this has proved very difficult to achieve in practice because of the barriers between professional groupings such as doctors and nurses (150). O'Neill and Cowman (151) note that to ensure successful teamwork community nurses require a deeper understanding of group process in primary care. There is a need to provide explicit formal

descriptions of the roles and responsibilities of PHCT members, which would include establishing clear professional boundaries. Hasler (152) argue that the PHCT has always had a highly complicated managerial structure, chiefly because the attached members are employed not only by an external body but one which is not the authority responsible for contracting with the GPs.

3.3.4 Diversity of nursing profiles in Scottish community

As already noted, the community nursing services in Scotland are delivered by a variety of nursing staff, which roles are described in this chapter, and were identified through the literature review. At the interface between all these services there may be overlap in which case a key worker should be agreed based on the needs of individuals (153). The role of district nurse and health visitor is described in more detail below, because they are important for the comparison with the role of family/community nurse in Slovenia. Historically, district nurse have been the main providers of nursing care in the community (154) and the largest group of community nurses in the UK and overall responsibility for assessing and planning how patients' and families' needs are met remains an essential element of their role (125). The district nurse works in partnership with patients, families and carers to provide skilled nursing care at home, promote and maintain patient independence, provide patient education, advice and support (153). Routinely they are exposed to complex care situations that require advanced assessment skills, complex decision making and specialist care planning, and referral of patients to other services (124). The range of services that they offer and the skills that are needed to deliver them is vast and all encompassing. The majorities are attempting to meet the needs of those with chronic illness, terminal illness, and acute episodes of illness as well as those requiring intensive and technological care, with no age limit defining their target audience. The location of care delivery is similarly varied and includes care delivery in the patients' home, residential care, and the independent sector and in general practice settings (155). Regardless of whether visiting is likely to be a single visit or extended over a period of time, the district nurse tries to build a picture of the physical, psychosocial and contextual components of patients' and carers' lives. The development of a close, trusting relationship in getting to know the patient with a serious chronic illness (and their family) enables the

district nurse to assess present and future care needs and act as a foundation for risk prevention and health promotion activities (125). Health promotion is one of the activities that district nurses are engaged in, and can enhance the public health aspect of their role by becoming more strategic and working in partnership and collaboration with other community nurses and agencies whose activities impact on the health of the public (5). However the challenge of community nursing in the 21st century includes the development of the district nurse's public health role (138). Toofany (120) concludes that the link between public health and health promotion makes it difficult for district nurses to identify their public health role, because they are not included in the third part of the nursing register as specialist community nurses, which implies that district nurses' activities are very clinically focused.

Health visitors were identified as being “pivotal in leading public health practice in communities by developing a wider, family centred public health role, and leading teams of other practitioners (136). Heath visiting services have traditionally aimed to encompass three component parts: child health development programme, generic health promotion across the lifespan, and community health, facilitating local development with residents (156). The service is delivered in a number of ways including: visits in the home, Clinics - both drop in and appointment only, group work with parents in a variety of venues - antenatal and postnatal, telephone support and advice. The role and function of the health visitor it is entrenched in public health with a key focus on accepting accountability and taking responsibility for tackling inequalities, social exclusion and promoting health of children, families and communities through early intervention and enduring preventive work (157). While evidence suggests that health visiting services may aspire to deliver across the life span, in reality the majority of health visitors is delivering almost exclusively in the area of child health, particularly the safeguarding of children in terms of prevention, but also actively working with vulnerable and at-risk families. They support families during the antenatal period, with the joys and stresses of a new baby; teach parents how to meet the nutritional needs of their infants and young children, and develop healthy lifestyles; enable parents in the most need to develop parenting skills and confidence and to connect them to further sources of support; monitor and assess the health and wellbeing of all infants and young children, detecting early any issues which require further action; act as the named professional and first point of contact for all health and wellbeing and child

protection issues for children under five and work with community groups and social services colleagues to promote health in the early years (158). Many health visitors also have specialist knowledge relating to specific areas of client need, for example domestic violence and post natal depression, as well as experience of working as a nurse or midwife in primary and/or secondary and/or tertiary health care.

Specialist community nurses traditionally had a key role in the hospital environment, but with the adoption of community care policies the model underpinning nursing practice shifted from a medical model delivered in hospitals to a social-educational model delivered in the community. Such nurses include mental health nurses, learning disability nurses and children's nurses. Sometimes they are based at a hospital and provide "outreach service" to people in their own homes; sometimes they are based in the community nursing services alongside district nurses (117). Community mental health nurses have a key role in promoting the mental and physical health and wellbeing of individuals and communities, and preventing and treating the development of mental health problems. They are highly skilled in assessing the impact of mental health problems on a person's thoughts, emotions, behavior, physical and social health (159). Learning disability is the specialist service of community learning disability nurses with some clinical care being provided with district nursing as key worker where clinical care is the prime objective (153). Their role is diverse and complex and much of the work is preventative, focused on the health education and promotion; surveillance; monitoring; advocacy and promoting client competence; clinical skills and service coordination (160). They work in multidisciplinary teams with other nurses and health and social welfare professionals to help people with learning disabilities with basic living skills and social activities to ensure they lead a healthy and fulfilling life. Community children's nursing represents a diverse and dynamic approach to providing care to children up to 18 years of age within their own homes and support to their families. The community children's nurse's role encompasses education, training, emotional support, and expert clinical care requiring high order cognitive skills in relation to decision making, problem solving and solution finding. Community children's nursing requires integration and joint working across health, social care, education and many other agencies (161), and the issue of transition to adult services must be clearly agreed at the interface with district nursing services (153).

General practice nurses represent a large and important group for community nursing, which are increasingly involved in health promotion and preventive work (128). They are RNs, who have usually undertaken further training and education and work in clinics and health centers and alongside GPs in doctors' surgeries, carrying out treatment on patients. Some of them follow up the patients they have seen in their clinics by visiting them at home (117). There are also community staff nurses, who do not have a specific specialist qualification to work in the community, but whose work involves caring for those on the district nurse caseload. They work across the whole range of ages from children to the elderly and their role includes assessment, communication and collaboration and also anticipatory care. Community staff nurses worked with the other community nursing professions to provide continuity of care; role overlap with the community nurses could be considerable but this depended on the discipline (95).

School nurses provide a variety of services such as providing health and sex education within schools, carrying out developmental screening, undertaking health interviews and administering immunisation programmes. School nurses can be employed either by the local health authority, primary care trust, community trust or sometimes by the school directly. The school nurse role had an emphasis on health promotion and preventative work but it has expanded over the years to deal with increasing social problems (95). Occupational health nurses are involved in the planning, delivery and evaluation of care to individuals within an occupational and rehabilitation setting (162). They can be employed as independent practitioners, or as part of a larger occupational health service team, often attached to a personnel department.

The family health nurse is the new type of professional nurse based on the WHO Europe concept. Their role is community based, multifaceted and includes helping individuals, families and communities to cope with illness and to improve their health. There is particular focus on holistic family care and a public health orientation. They work in a distinct geographic area whose population is served by one or two district nursing team(s) within which an FHN is working (16). In this part we would like to mention the role of midwives, although they have a different program and education from nurses, but they are also active in the local community and visiting pregnant women, mothers and newborns at

home. Community midwives are key professionals in ensuring that women have a safe and emotionally satisfying experience during their pregnancy, childbirth and postnatal period (163). They provide health education and parenting support for the first 28 days after the birth when women and their partners are adjusting to their parental role, after which care transfers to a health visitor. More midwives now work in the community, providing services in women's homes, local clinics, children's centers and GP surgeries.

3.3.5 Family health nurse pilot

Macduff (24) suggests that the WHO model of FHN is particularly suited to the needs of Scotland's remote and rural communities. According to the General Household survey classification scheme (164) locations are remote and rural if their main settlements have a population of less than 3000 and are more than a thirty minute drive time from a settlement of 10,000 people or more. This applies to many parts of the Highland and Island regions. Within these regions populations are characteristically sparse, ageing and declining in numbers. Health profiles are often poor, with high incidences of cardiovascular disease and cancer, and socio-economic problems such as unemployment and poverty are relatively widespread (16). Nursing built on traditional models of education and service has led to a number of difficulties in these areas where is increasing difficulty in recruiting, developing and retaining all health professionals, and within nursing and midwifery sustaining the traditional double and triple duty roles has become particularly problematic (103). The double and triple duty nurses had undertaken educational programmes in general nursing, midwifery, health visiting, school nursing and district nursing. Macduff (16) emphasises that geographic isolation is associated with transport difficulties, and the regions suffer from migration of the young to urban towns and cities. Recruitment and retention of skilled nursing staff has become increasingly difficult.

Proctor (cited in 16) in the Report of a multi-disciplinary conference explains how the concept of FHN fits to the current Scottish context: "The FHN concept was developed primarily for those parts of Europe which do not currently have primary care services. The FHN, as a skilled generalist, would work alongside a family health doctor to meet the health needs of a community. The generalist family health physician equates very well

with current models of UK general practice, but the FHN concept is quite different from current models of nursing practice". Sweet and Dougall (116) suggest that proposal that a new model was required, which coupled with the title FHN, implied a need to strengthen the relationship between nurses in rural and island areas and families they dealt with, as well as a recognition that this relationship, as it currently stood, was not providing optimal benefits to health.

Scotland joined the WHO Europe Family Health Nursing multinational study in 1999 as the lead pilot country. Two reasons underpinned the decision that Scotland participate in this study: (1st) The policy emphasis on health improvement rather than purely health care, and the focus on family rather than individuals within the FHN model creates a role that is focused not just on health care, but on the wider determinants of health. (2nd) The difficulties associated with operating a specialist model of practice within small remote communities. These include recruitment and retention of nurses, professional isolation, and increasing problems of maintaining skills and competencies in sparsely populated areas (23).

The FHN role in Scotland has been underpinned by three principles:

- a 'generalist' approach to practice that encompasses a broad range of duties, with the FHN acting as the first point of contact for individuals and families and referring on to specialists when greater expertise is required
- a model based on health as well as illness – the FHN is expected to take a lead role in preventing illness and promoting health in addition to caring for members of the community who are ill and require nursing care
- a role founded on the principle of caring for families as well as the individual (33).

Fundamental to the role is the unique approach to family assessment and care, which is highly valued by service users (165). Working in a family-focused way is a key to developing trust and building the confidence of families to take greater responsibility for their own health.

In 2000 SEHD began preparatory work for a Scottish Family Health Nursing pilot project, which has been piloted in Scotland, since 2001 in remote and rural areas, and in 2005 in an urban area. Four regions participated in pilot study: Highland, Western Isles, Argyll and Clyde, and Orkney. The Project was established initially as a two year pilot, between 2001 and 2003, in line with WHO guidance (23) and to achieve these specific objectives: to test the FHN model within remote and rural areas and to develop and test an education programme based on the multi-national curriculum from WHO Europe. In February 2001 the Centre for Nurse Practice Research and Development at Robert Gordon University, Aberdeen was commissioned by SEHD to undertake an independent research evaluation (33). The study's remit was to evaluate the operation and impact of family health nursing in these remote and rural areas within Scotland, which included evaluation programme and the identification of implications for extending family health nursing into other Scottish regions (16).

Stirling University was commissioned from SEHD to provide an educational programme for registered nurses with two years post-registration qualifying experience to prepare nurses from Scotland's remote and rural regions (166). The course was designed to be compatible with a curriculum suggested by WHO Europe, and with the UKCC (now NMC) framework for nursing specialist practice qualifications (103). Students are generally recruited from the existing nursing workforces and had extensive previous experience in community settings as midwives, district nurses and health visitors (16). For many of them, this meant that at the end of the programme they would return to their former practice areas to take up their new role as a FHN (167). On completion of the programme, the FHN was expected to be competent as a: care provider, decision maker, communicator, community leader and manager (23). Macduff (16) note that while the Scottish FHN curriculum identifies some content as core, this is integrated into three modules: working with families; communication; and research, decision-making and evaluation in clinical practice. Similarities with other community-based programmes are evident through the title of some modules (23).

The pilot project was conducted in two phases. The first phase started with an educational programme in 2001 and was completed by eleven students, and a further twenty students undertook and completed the course in 2002. The Family Health Nursing in Scotland

report (23) summarised progress with the pilot, and set out a programme for a second phase of the FHN project in Scotland. Second phase ran from 2003 to 2006 and involved the education of eighteen more FHNs. This phase has the aims of: consolidating FHN practice in remote and rural areas; testing the suitability of the role in an urban setting; developing the educational programme; and informing the development of Scottish community nursing education and practice (16). A follow-up study by Macduff (34) presents findings from a study which followed up the progress of remote and rural Scottish family health nursing during 2004. Macduff (34) says that one of the most striking findings from this study was the flexibility and wide scope of the role in terms of providing generalist community health nurse practice.

In 2004, with the establishment of the third part of NMC register for "Registered Specialist Community Public Health Nurses", the FHN was recognised at national level as a public health nursing qualification, but remains the smallest sub-group of this part of register (16).

4 DISCUSSION

The aim of this study was to describe and compare the systems of community nursing in Slovenia and Scotland, and to discuss their advantages and disadvantages. In this chapter we will present the most important differences between these two systems, which are the result of different historical and political influences, the development of the nursing profession, as well as the different educational systems in each country. Differences in community nursing are also the result of global changes in political and economic fields, bringing about rapid changes in public and community health, as well as in the social care landscape in each of the European nations. The European policy is increasingly shifting towards a primary-care led health service, as is evident from WHO policy documents – the Vienna and Munich Declaration. These documents highlight the new role of nurses in primary health care, especially in community nursing, which is directed towards empowering individuals, families and communities to become more self-reliant and to take charge of their health development.

The main observed difference that we found is that between the generalist nursing role and the specialist nursing role. In Slovenia, the role of generalist nurses has developed through history and the polyvalent family/community nursing model, known as the Patronage Nursing model has been used since 1957. In reviewing the literature we observed this term to be specific for the area of community nursing in Slovenia, whereas for the purpose of worldwide understanding the term family/community nursing, as proposed by WHO, is used. The existing model seems to be similar to FHN model promoted by WHO. The Slovenian representatives in the WHO multi-national study believe that the Slovenian model underpinned the WHO definition of the FHN (6). The foundations of the family/community nursing model were laid in 1971, when the "Elaborate of the family/community nursing services" (68) was confirmed, and was in effect until Slovenia's independence in 1991. Nurses saw the need for a comprehensive treatment of the individual and his/her family in the community where they lived, thus combining the tasks of midwives, social workers and nursing care at home into a single family/community nursing service. Ever since 1974, when polyvalent family/community nursing services became mandatory by law for all healthcare organizations, the nurse's role has focused on

the family throughout the life span of its members, providing acute care as well as health promotion and prevention. Since then, the family/community nurse has been the only health professional to work with the whole family in their homes and in the local community, and represents the link between family and family physician. Many European countries envy the Slovenian system of organization of family/community nursing and the treatment of family as a whole in the community where it lives. However, independence has brought political changes and, consequently, changes in health care. The main problem in Slovenia today is that family/community nursing services are witnessing a reduction of preventive activities as a result of the increasing number of curative visits, which have become a priority, and the reduction of the financially recognized preventive visits. As a consequence family/community nursing is slowly losing its autonomy.

In contrast to Slovenia, Scotland has a large number of specialist community nurses, whose activities cover various fields of nursing. Professionally speaking, the conviction that specialists are better able to keep up to date in their field and achieve expert practitioner status, does not necessarily guarantee quality. McKenna et al (22) note that even though increasing specialization across all disciplines in nursing worldwide makes it difficult for a generalist nurse to provide care that equates to best practice in each discipline, it often leads to role conflict, role overlap and role confusion. The Scottish Government (21) notes that not only are individuals, carers, families and communities unsure as to which nursing service to access to meet their particular needs, but that health and social care professionals are frustrated by the plethora of nursing roles and titles existing in community services, which can lead to unnecessary delays in accessing appropriate nursing support and advice. There is a crossover of roles and any one day a family home may have a visit from a district nurse, midwife and health visitor, probably for different family members.

Despite all the advantages and disadvantages of the generalist and specialist nursing role many authors (77, 139, 168) believe that the nursing profession and health care both need to find ways of securing the advantages of each to produce the best possible patient care. WHO points out that “The choice of the term generalist was never intended to place the generalist nurse in opposition to, or in preference to, the specialist. Rather it was intended to indicate the need for a sound, broad based basic education in nursing with a strong

emphasis on PHC" (cited in 77). It is our opinion that in the context of family/community treatment, where generalist nurses operate, the help, support and mentorship of specialist nurses in the treatment of individual patients is very welcome. It is certain that when assisted by specialist nurses, generalist nurses have the opportunity to reinforce their knowledge in particular fields of community nursing. Generalist nurses can be proud of their broad range of competencies and skills because they are experts in knowing the broader and more holistic aspects of patient's care, but they cannot be as skilled and knowledgeable as their specialist nurse colleagues. Castledine (139) says that this is particularly evident when dealing with older people these days, who may have several specialist medical problems and need a generalist nurse to understand and co-ordinate their overall nursing care.

As part of the Health21 health policy within the framework of the WHO, the FHN model was introduced as an approach to strengthening the contribution of nursing and midwifery in Europe. Scotland saw the opportunity of implementing the FHN concept to solve the problems dealing with the plethora of different roles and titles of the community nursing staff. This enabled FHNs to deal with health issues and individuals who would otherwise have "fallen through the cracks" of more specialist services. We will try to answer on the question "Is there any difference in organization of community nursing in Scotland after implementation of the FHN and whether patients were satisfied with the change"? From the literature review we find that with the implementation of the FHN model in the Scottish community the focus of care has changed putting emphasis on the family and wider community. Health promotion, health education and public health have become more important and a proactive, holistic and long-term approach to health is being adopted when dealing with family and community problems. Hennessy and Gladin (6) conclude that with the FHN role, families receive more comprehensive service. Parfitt et al (165) add that service users and carers value the FHN's accessibility and holistic perspective for all members of the family. The main reason for users' high levels of satisfaction is their feeling that the FHNs have sufficient time available to develop a holistic perspective on the full range of issues confronting the family. In his study on the progress of family health nursing, Macduff (24) concludes that a generalist role in remote and rural regions of Scotland has proven to be very useful for community nurses, their PHCT colleagues,

patients, their families, and the community as a whole. Despite the positive aspects of FHN's role in Scotland, SEHD (33) reports that in areas where there is inadequate or no multi-disciplinary community health care provision, the WHO Europe FHN-led service has the potential to cooperate with the nurse as the key co-ordinator of all services and referrals. There is a need for much stronger local programmes of support and facilitation if the role is to be developed and sustained. The difference in FHN educational programme from other community-based programmes has neither facilitated the professional understanding of the role nor allowed the debate between practitioners regarding role boundaries and optimum skill-mixing in various contexts of practice to take place. Some authors (16, 103) believe that this may have contributed to the confusions and perceived threats to established nursing, midwifery and health visiting roles and consequently may have impeded the adaptation and development of a family health nursing approach to community-based health care. As a consequence of all this, the Scottish Government formed and introduced the new service model for nursing, and family health nursing pilot in Scotland influenced the development of the Community Health Nurse model. The new role was introduced "to create greatest benefits to individuals, careers, families and communities" (21), and combines district nursing, health visiting, school nursing and family health nursing into a single community health nurse role.

Other UK countries had a much more guarded point of view regarding the idea of introducing a skilled generalist community nurse. In the 1990's there was a profusion of new specialist role titles within the UK. The introduction of the FHN concept caused a dearth of interest and critical engagement by managers, educationalists and clinicians. Macduff (16) explains that one of the possible explanations for this was that at that time the family was not particularly emphasised within the UK health care political agenda. Many community nurses were not enthusiastic about the implementation of the FHN role and were convinced that the role of the health visiting, district nursing and community midwifery were different and did not overlap or interrelate in practice. Many officials believed that the implementation in other UK countries would be too radical according to the existing health care system. The majority of the nursing staff continually defended and protected their specialty and fought against the introduction of certain changes in practice, which could also be the reason why the FHN model was not implemented in the way the

Scottish Government had hoped. There was probably a certain fear among specialist nurses, that the FHN would eventually replace their role in the community.

The process of implementation of the FHN concept differs between Slovenia and Scotland due to divergent organizations of the health care system and roles of the community nurses. Because Slovenia already has an existing family/community nursing model similar to the WHO FHN model, it has had some difficulties and delays in initiating an appropriate educational programme for a pilot study. When researching the literature from the aspect of education in Slovenia, we found that Patronage nursing specialization lasted only a few years because of the small number of participants and lack of interest, which may be also associated with a small population in the country. The reason for this is that the RN with basic general nurse education, gains knowledge for the treatment of patients and families in the communities. It seems reasonable that any RN, who wants to work in community nursing, previously obtains a certain number years of experience in specific clinical settings, especially from the perspective of safety and responsibility, two very important aspects needed for both independent work and decision-making in the community.

The skilled generalist role is the underpinning core of the FHN role and Parfitt et al (165) underline that it is particularly suited to providing services to families with multiple healthcare needs. For the majority of participating counties in the WHO multi-national study, creating a generalist role has been the most difficult aspect to realise for nurses and other health professionals, because it is difficult to integrate a generalist model into an environment, where a specialist model of nursing is being used. In addition to poor understanding, recognition and appreciation of the FHN role, Finland saw the obstacles of role implementation in the lack of team work, issues around responsibilities and autonomy. Portugal perceived poor understanding of the FHN role and logistical barriers with other professionals who work in the community. In Tajikistan the FHN concept was included in the government's nursing development system, but until now there has been no evidence of its implementation in practice. Hennesy and Gladin (6) note that all participating countries saw the need for increased political, economic and financial support, which is crucial for the success of the FHN. Parfitt (169) adds that the success of the role in other countries will depend upon its position in relation to the historical health care system.

The target population of community nursing is another important difference that was observed in discussions around the organizational structure of community health nursing. Activities performed by family/community nurses in Slovenia have always focused on the family as a whole and on the individual as part of the family and the environment where they live. Whereas in Scotland, due to its emphasis on specialist knowledge, community nursing treatment focuses on the individual, with reduced importance of the concept of the family and the community, which may reduce the quality of treatment. The concept of the family expands the view of the treatment of individuals to other aspects (eg, sociological), which inevitably leads to a high-quality impact on patient and family care. This could also be the reason why the FHN model has not been fully implemented in practice.

5 CONCLUSION

With the scientific study of the literature we came to the conclusion that the differences between the organization of the community nursing service in Slovenia and Scotland are the result of several political and cultural changes that influenced the development of nursing profession. Each of the two systems described in this thesis has its advantages - Scotland in the treatment of the individual patient, and Slovenia's treatment from the perspective of the family. This is related to the role of specialist and generalist nursing in the community.

It is safe to say that the system of PHC in Slovenia is so organized that it enables the operation of generalist nurses in community nursing. The specialist nurse would have difficulties integrating into the already existing system, due to low population density in the country, and the associated number of patients, suitable for treatment in the respective specialized fields. Because of the limited number of cases in a particular community, every specialist nurse would have to cover a very large geographical area, which would in turn present a big organizational problem. From this point of view, the implementation of the FHN model in Scotland's remote and rural communities prove to be easier than in other countries, because many community nurses in these areas already potentially have a function based on FHN concept as they combine double or triple duty roles.

It is certain that the guidelines and WHO recommendations are not suitable for implementation in all member countries. The implementation of new models and concepts, as well as the improvement and restoration of health systems in individual countries, are affected by general factors such as the number of residents, population settlement, the school system, economic status, and the level of country development.

When the WHO considers changes and improvements in health systems, particularly in terms of the treatment of individuals, families and communities, it should undoubtedly take into account the broader aspects of each Member State, and develop the proposals and guidelines that would be applied in both, the larger and smaller countries. Even though it may seem unrealistic to search for solutions that would be universal for all health care

systems, it would be wise to search for those that represent the best solutions for treatment of the individual, the family and the community.

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